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REPORT DOCUMENTATION PAGE		READ INSTRUCTIONS BEFORE COMPLETING FORM
1. REPORT NUMBER AFIT/CI/NR 88- 94	2. GOVT ACCESSION NO.	3. RECIPIENT'S CATALOG NUMBER
4. TITLE (and Subtitle) REMOVING CULTURAL BARRIERS TO CARE DURING CHILDBEARING: A CONTINUING EDUCATION MODULE		5. TYPE OF REPORT & PERIOD COVERED MS THESIS
7. AUTHOR(s) DEBRA A. ERICKSON-OWENS DEBORAH M. GOOD RUBY M. ZDENEK		6. PERFORMING ORG. REPORT NUMBER
9. PERFORMING ORGANIZATION NAME AND ADDRESS AFIT STUDENT AT: UNIVERSITY OF UTAH		8. CONTRACT OR GRANT NUMBER(s)
CONTROLLING OFFICE NAME AND ADDRESS		10. PROGRAM ELEMENT, PROJECT, TASK AREA & WORK UNIT NUMBERS
11. MONITORING AGENCY NAME & ADDRESS (if different from Controlling Office) AFIT/NR Wright-Patterson AFB OH 45433-6583		12. REPORT DATE 1988
		13. NUMBER OF PAGES 111
		15. SECURITY CLASS. (of this report) UNCLASSIFIED
		15a. DECLASSIFICATION/DOWNGRADING SCHEDULE
5. DISTRIBUTION STATEMENT (of this Report) DISTRIBUTED UNLIMITED: APPROVED FOR PUBLIC RELEASE		
17. DISTRIBUTION STATEMENT (of the abstract entered in Block 20, if different from report) SAME AS REPORT		
18. SUPPLEMENTARY NOTES Approved for Public Release: IAW AFR 190-1 LYNN E. WOLAVER <i>Lynn Wolaver</i> 20 Feb 88 Dean for Research and Professional Development Air Force Institute of Technology Wright-Patterson AFB OH 45433-6583		
19. KEY WORDS (Continue on reverse side if necessary and identify by block number)		
20. ABSTRACT (Continue on reverse side if necessary and identify by block number) ATTACHED		

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INTRODUCTION TO THE THESIS OPTION PROJECT: REMOVING CULTURAL BARRIERS TO CARE DURING CHILDBEARING: A CONTINUING EDUCATION MODULE

As experienced registered nurses in the obstetrical area within the United States Air Force (USAF), we felt a need to focus on specific cultural groups and their unique needs during childbearing. We identified the two largest groups serviced by the USAF (excluding caucasian Americans).

We utilized a telephone questionnaire completed by Obstetrical^{and}/Gynecological Nurse Practitioners (~~Ob/Gyn NPs~~), Certified Nurse Midwives (CNMs), and Charge Nurses of the Ob/Gyn clinics currently on active duty with the USAF to help us identify these groups: Asians (specifically Pilipino and Korean), and Hispanic (specifically Mexican-American). Through literature review we compiled the most up-to-date information available to provide guidelines for care providers and clinical nurses in caring for these unique groups. *Keywords: Health care, pregnancy, women, infants.*

The objectives we accomplished in this thesis option are as follows: *Research on, medical practices, women, infants.*

1. Identify the cultural obstetrical population serviced by Ob/Gyn NPs and CNMs in the USAF.
2. Provide the basic tenets of transcultural health care and their importance in the provision of care.
3. Identify the unique needs of the two largest cultural obstetrical groups serviced by USAF CNMs and Ob/Gyn NPs during childbearing.

4. Create a continuing education module to assist Ob/Gyn NPs, CNMs, and the obstetrical nursing staff in providing individualized quality care to these clients.

The continuing education module will be distributed to the Health Education Coordinator at each USAF medical facility. The module will be made available to all interested health care providers. Ob/Gyn personnel will be especially encouraged to complete the module.

A list of general objectives is provided in the introduction of the module and specific sub-objectives are provided for each portion. A posttest is available to earn continuing education credit and to test the learner's newly acquired transcultural knowledge.

The module is divided into three parts. Each student concentrated her literature review on the specific areas listed below:

Ruby M. Zdenek: Basic tenets of transcultural health care and their importance in the provision of care.

Debra Erickson-Owens: Mexican-American beliefs and practices.

Deborah M. Good: Asian beliefs and practices (specifically Pilipino and Korean.

Following the initial portion dealing with concepts of transcultural health care, the following components of childbearing were addressed:



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Removing Cultural Barriers to Care During Childbearing:

A Continuing Education Module

Debra A. Erickson-Owens

Deborah M. Good

Ruby M. Zdenek

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INTRODUCTION

Women across cultures and throughout history are united through the biological and sociocultural phenomena of conception and birth. According to Thornton-Williams (1987, p. 2), "birthing outside of cultural context presents problems for women". There is no questioning the need for Air Force care providers, whose origins are the dominant American culture, to understand and be sensitive to the unique beliefs and health care needs of women and their families who do not ascribe to the culturally patterned beliefs and behaviors of the dominant culture in the United States. Jensen and Bobak (1985, p. 66) state, "becoming knowledgeable about, and sensitive to, beliefs, values, and practices concerning childbearing in our multicultural society poses unique challenges for our nurses and other health care providers". In understanding the culture, language, traditional and religious values and beliefs, the provider will foster a relationship of respect and trust which is invaluable in providing effective care. Effective care during the childbearing year will help reduce perinatal morbidity/mortality and improve the outcomes of women and infants from other cultures.

A complete analysis of all cultures is impossible, due to: 1) limited research, 2) the vast number of cultural variations, and 3) the ever changing belief systems and practices.

In creating this module, a needs assessment was accomplished utilizing Obstetrical/Gynecological health providers in twenty

United States Air Force facilities. The two most common transcultural groups identified by the providers were Asians and Hispanics (specifically Mexican-Americans).

With the needs assessment complete, a literature review was done focusing on these two transcultural groups. The information presented here is an attempt to provide a basic knowledge of transcultural nursing and to assist health providers to gain an increased sensitivity to the cultural needs of their clients (client/patient are interchangeable throughout this module).

Although this module is presented in three parts, the reader must complete all portions and the cumulative posttest to receive continuing education credit. The module should take no more than four hours to complete.

Upon completion of this module the reader will be able to:

1. Identify the importance of care provider sensitivity in dealing with clients from different cultural groups.
2. Detect clues in care provider-client interactions which illustrate cultural differences.
3. Distinguish between effective and noneffective practices in dealing with clients from different cultural groups.
4. Identify the most common barriers affecting the provider-client relationship.
5. Identify cultural philosophies which influence the provision of effective health care.

PART I: AN INTRODUCTION TO TRANSCULTURAL HEALTH CARE

By

Ruby M. Zdenek, Captain, United States Air Force, Nurse Corps

Transcultural Health Care Objectives

At the completion of this portion of the module, the reader will be able to fulfill the following objectives:

1. Define transcultural nursing.
2. State reasons for the recent increased focus on transcultural health care.
3. State the goal of transcultural health care.
4. State the effects of ethnocentrism on the quality of care.
5. Discuss the importance of health-illness viewpoints in relation to cultural values.
6. Discuss the appropriate use of culturological assessment tools.

Introduction To Transcultural Health Care

"Safe effective care" describes the care providers must give to retain licensure. However, this type of care is not being offered if we do not consider cultural differences. People have a right to have their sociocultural backgrounds understood in the same way they expect their physical and psychological needs to be recognized, respected and understood (Branch & Paxton, 1976; Leininger, 1978).

Increasingly, in many parts of the world health care providers are beginning to realize they have a professional responsibility to learn about the lifestyles of other cultural groups and to use this knowledge to give safe, comprehensive, effective care. Concern for the welfare of mankind is challenging health care workers to understand cultural differences. With increasing world trade, international travel and the efforts to decrease tensions between countries, we continually interact with people from widely differing cultures within short periods of time. As a consequence, health care providers are expected to know, understand, and interact favorably with strangers from diverse cultural backgrounds (Leininger, 1978; Rothenburger, 1987; Tripp-Reimer, 1984). This necessitates an awareness of different cultures and the creative use of such knowledge. Transcultural knowledge can help the health care provider work more comfortably and effectively with people of different backgrounds. If personalized, culturally

appropriate care is not given, clients show their displeasure with services, become uncooperative, and may withdraw, or show other signs of discontent. Transcultural health care can also offer insights about one's own culture in relationship to another culture (Leininger, 1978). However, the caregiver must be sensitive to the differences between their own and other's cultural backgrounds for these insights to be realized. Health care providers cannot be expected to know and understand all cultures of the world, (a lifetime goal) but it is possible to know three or four cultures in depth (Branch & Paxton, 1976; Leininger, 1978).

Nursing is an integrative discipline which blends, borrows, and adapts knowledge from other fields. Whatever influences patient care is appropriate and necessary for use. As care providers, we act, react, and interact with people throughout the life span, with each interaction occurring within a cultural context. Whatever affects human behavior, including emotions, motivation, social organization, and belief systems, affects health care (Osborne, 1976).

Transcultural nursing is a blending of anthropology and nursing (Brink, 1976). According to Leininger (1978, p. 53), "it is an evolving body of knowledge and practices regarding health and illness care patterns from a comparative perspective of at least two or more cultures to determine the major care features and health services of each".

Anthropologists stress collection of information about

cultures by obtaining first hand knowledge from informants. Leininger (1978, p. 55) states, "cultural history data of other cultures can be particularly helpful in making transcultural health analysis and determining care implications". It provides an accurate account of people's behavior and how they perceive their environment, enabling us to gain first hand knowledge of how people view themselves. This approach can give health care providers fresh insights about the client, the client's family, and significant people in the client's community who influence their behavior. Such cultural data also enables the health care provider to use the client's views of health and illness without interjecting their own personal views about client behavior (Leininger, 1978; Spector, 1985).

The goal of transcultural health care is to identify, test, understand, and use culturally derived knowledge and practices in order to provide culture-specific care (Branch & Paxton, 1976; Osborne, 1976).

To clarify this presentation, the following definitions are provided: culture, cultural imposition, culture shock, dominant group, ethnicity, and ethnocentrism.

Definitions

CULTURE is defined as the customs and shared behaviors of groups of people. It is not biologically inherited, but learned and transmitted from one generation to the next through socialization. Culture is a means for identification of members

of a group and can be a valuable factor in providing for the emotional, physical, and social health of group members. It is a product of an individual's recurrent responses to life's daily problems, and may be viewed as a blueprint for living which guides a group's actions, thoughts and sentiments, providing solutions to the life problems of existence. Culture is reflected in problem solving, language, dress, food, traditions and social institutions. It is the dominant force in determining health-illness and caring behaviors. Culture is universal in the human experience, yet each local and regional manifestation is unique. Finally, it is dynamic and ever-changing (Leininger, 1978; Orque, Bloch, & Monrroy, 1983; Spector, 1985).

Cultural pride is evident in many groups of people in the United States. It is the guideline for actions and beliefs, providing the thrust for meeting the stressors and difficulties of life. Cultural identity is an integral part of cultural pride. (Leininger, 1978).

CULTURAL IMPOSITION is the tendency of members of the dominant cultural group to impose their beliefs, practices and values on members of the less dominant cultural groups. It is often closely related to ethnocentric biases in which members of the dominant cultural group are convinced that their way is the right (only) way and that only they have the necessary knowledge (Leininger, 1978).

CULTURE SHOCK is defined as feelings of helplessness and discomfort and a state of disorientation experienced by an

outsider attempting to comprehend or effectively adapt to a different cultural group. It may make a person feel angry and uncomfortable when in contact with the unfamiliar cultural group (Brink, 1976).

DOMINANT GROUP refers to the group that by virtue of size, perceived status, or other factors, determines acceptable behavior in a society (Leininger, 1978).

ETHNICITY is, according to Werner (1979, p. 44), "a group's affiliation due to a shared linguistic, racial, and/or cultural background".

ETHNOCENTRISM refers to the belief that one's own way of living, acting, and existing is the best (or preferred) way to live. This idea tends to dominate Western thinking (Leininger, 1970; Orque, Bloch, & Monrroy, 1983; Spector, 1985). Knowledge about local and distant cultures must enter our awareness so that changes are produced in attitudes and behavior toward various cultural groups. No longer can we have disregard for cultures different from our own. As we become more knowledgeable and begin to evaluate the beliefs and positions of different cultures, ethnocentrism and the tendency for cultural imposition will be reduced.

Basic Tenets Of Transcultural Health Care

Immigrants and their descendents constitute most of the population of the United States. In the early days of America, immigrants arrived from other countries and began the socialization process to "fit" into the mainstream "American

culture". For the children, this process was accomplished through school attendance, where the majority of socialization took place. There, they learned the new language and customs, discarding as much of their old culture as possible, effectively resulting in psychic repression of their individual cultures. Although most immigrants lived in ethnic communities, they attempted to adapt their lifestyles to that of the main dominant group to gain employment and acceptance. This was a necessity for survival (Spector, 1985).

Our American heritage reflects a variety of cultural groups. Accommodation of different cultures into the "American way of life" has been a problem and challenge from the start. Some Americans may not be aware of, or may deny the existence of a variety of subcultures in our society (Leininger, 1978). The events of the 1960's gave society an awareness of gaps that divided the American population. The dream of people assimilating into an "American culture" or the belief that America is a "melting pot" proved to be a myth. People aware of their own culture and proud of their heritage were demanding acceptance and appreciation of their ethnicity (Rothenberger, 1987; Spector, 1985).

On arrival in the United States, the immigrants possessed definitions of health and illness as well as methods of treating these illnesses or deficiencies (Spector, 1985).

Health care systems are part of the social structure. Although this concept is difficult to comprehend for most health

care workers, it is evident when Western practitioners work in developing countries or in nonwestern societies. For Western health workers to realize that indigenous people have had a health system prior to their arrival may be an entirely new idea. It is often stressful for them to discover that their ideas are not as helpful as they perceive them to be (Branch & Paxton, 1976; Leininger, 1978).

American health care practices tend to rely upon unicultural professional values which are largely derived from the dominant Anglo-American caring values and behavioral expectations. The American care provider generally holds the "Old Yankee" class of values which is future oriented, and values the individual's ability to make decisions for themselves. Therefore, the caregiver may become irritated with the client who will not commit to a course of action or treatment plan during their office visit, not realizing the client's culture directs them to include other members of the family in the decision-making process. (Kluckhohn, 1976; MacGregor, 1976). Gaining knowledge of other cultural groups and experiencing different kinds of health care practices helps to reduce ethnocentric tendencies to rely on one (or only a few) set of values (Leininger, 1978). Health care providers make diagnoses, and develop treatments based on the norms and values of the professional group to which they belong (Spector, 1985).

Clients' beliefs about disease causation and treatments must be understood by the health care provider before effective health

guidance can be offered to them. Culture greatly influences how people remain well or engage in sickness behavior (Spector, 1985). The American care provider believes disease is controllable and the client is neither good nor evil but ill. This is in conflict with the client who believes illness is a punishment for some evil or God's will (Kluckhohn, 1976). Health beliefs are culturally oriented, community based, and maintained from the people's viewpoint. Are diseases seen as an act of God? Something over which the client has no control? Is treatment a matter of allowing nature to take it's course? Is it dependence on God's will? If the client holds these attitudes, it is difficult to persuade him/her to practice preventive health care because they see little or no value in it (Brownlee, 1978; O'Brien, 1982).

When caregivers come into contact with clients who do not follow the prescribed regimen (i.e. take the medication prescribed, return for a follow-up appointment, change their diet) they often label them as uncooperative or noncompliant, and react negatively to them. In many cases, the clients may have values and beliefs about health and illness which differ a great deal from the values of the caregiver. Rather than reacting with anger, the caregiver must take the time to explore why the medications were not taken. Could the client afford them? Did the client feel they would be helpful? (Branch & Paxton, 1976; MacGregor, 1976). The feelings a health care provider may experience in this situation; such as, helplessness, frustration,

a sense of failure, and anger, may surface when working with a large number of people of a different culture (Branch & Paxton, 1976). These signals may unconsciously be transmitted to clients. Transcultural health care requires an assessment of both parties in the interaction since both come to the situation with preconceived notions. Conflicts that arise when expectations are not met become insoluble unless one or both of the parties intervenes (Branch & Paxton, 1976; Brink, 1976; Osborne, 1976).

Misunderstandings between providers and clients often have roots in transcultural differences, whether related to language or attitudes. Communication is not by words alone. Even though the caregiver and the client may speak the same language there are different points of etiquette each of us observe and operate under because of the culture we grew up in. For example, take the case of the Swedish client who was admitted to the hospital. He spoke English very well, yet whenever the nurses asked him if he wanted anything to drink, he would decline. After two days of these interactions, his wife came to the nurses' station and complained that her husband was not receiving good care. On further discussion, it was discovered that in Sweden it is common procedure to decline the first two or three offers; however it is also customary for the person offering to offer three or four times. Consequently, the health care provider should ponder the reason for any bit of behavior rather than glossing over it or labeling it as insignificant (Dawes, 1986; Hall & Whyte, 1976).

According to Leininger (1978, p. 75), "in studying people of

different cultures, it is important to understand their health-illness viewpoints, how these viewpoints relate to cultural values, and the client's goals for health care". When health care providers are not aware of differences in values and beliefs between cultural groups they tend to have difficulty trying to assist unfamiliar cultural groups. Even with the best of intentions, if health workers do not have the proper preparation for contact with an unfamiliar group they may become frustrated and revert to methods of dealing with clients which are familiar to them.

Individuals from different cultures perceive and classify their health problems in specific ways and have certain expectations of how they should be helped. To ignore these differences may interfere with the health workers ability to help the client and limit the client's progress toward their own culturally defined health state. There are still wide variations in beliefs about what constitutes "normal" and "abnormal" health behavior (Leininger, 1978). For example, O'Brien (1982) describes the perception of health among low income Americans as the ability to work; while in middle class families an upper respiratory infection may keep one home from work.

Another difference between cultural groups may be found in the system of health care itself. According to Leininger (1978, p. 64) "in transcultural health care, there are generally two kinds of health care systems; an indigenous, or traditional system and a professional, or Western style system. These may or

may not be well integrated. The indigenous system represents the traditional folk health care modalities while the professional provider is a member of a contemporary system maintained by people who have pursued a formal course of study. Usually the indigenous system has been in place for many years and reflects the use of folk medicine and home treatments. These indigenous health care providers are often viewed as first line practitioners by the local people. Although not trained in a formal program, they have completed some form of an apprenticeship". The test of their effectiveness is the use of their care modalities through time. Although professional groups hope for the demise of these practitioners, they do fulfill a need and can be seen to increase in use in areas where the modern health care systems leave gaps, uncertainties, and/or disappointments in health care (Branch & Paxton, 1976; Leininger, 1978).

Leininger (1978, p. 54) states "the local people are often more aware of the professional health care system than the health care providers are aware of the indigenous system. When the professional health care provider is made aware of the indigenous system they are often surprised and may declare the alternate system unscientific or quackery. This labels it as irrelevant; but professionals who fail to recognize its importance miss a great chance to understand the values and needs of the people, and the opportunity to provide health care linkages between the two systems". Although the tendency is to view indigenous health

and illness beliefs and practices as superstitious and unscientific, Americans of the dominant cultural group may also hold such beliefs. For example, who hasn't heard of chicken soup for a cold; or the saying of "starve a cold and feed a fever"? While as health care providers we may not totally believe these methods, at times we follow them just to "be on the safe side". As care providers, we must develop flexibility using our resources and strengths to accomodate cultural group differences and needs of our clients (Spector, 1985). Until the professional system becomes more culturally attuned to the local people's needs, and provides less costly and more readily available services, both systems would seem to have a role in society.

Guidelines For Transcultural Health Care

One of the new and most challenging problems for researchers in health and social services is to accurately describe and explain health and illness behaviors from the client's point of view. Superficial knowledge, ethnocentric tendencies and false assumptions about cultural groups will not suffice if health workers are to be successful in helping people from other cultures. Health workers with receptive attitudes will gain valuable insights and special knowledge about indigenous health systems and can also avoid problems in interpersonal communications. These caregivers will be more likely to be able to administer effective health programs (Leininger, 1978).

Cultural differences between care providers and clients may influence the quality of care. Usually when two strangers meet

whose cultural backgrounds are not known there is a "feeling out" period during which trivialities are exchanged prior to more direct probing questions. The client may only risk talking about nonthreatening subjects until they receive some feedback from the provider on a social, religious, or personal level that gives them some common ground. Once a common ground is established, the conversation will become more spontaneous and meaningful, with the client discussing areas about which they may be more uncomfortable (Leininger, 1978). Allowing the client to address subjects with which they are comfortable also gives the health care provider the opportunity for further exploration of perceptions and beliefs with the client. This results in a more individualized plan of care, utilizing a cultural context more likely to meet the needs of the client. The resulting satisfaction for both members in this positive interaction does much to enhance the client's perception of their hospital stay or office visit.

An open, objective attitude about an individual's culture and the way they express themselves must be maintained. Holistic views of individuals in the total cultural context and environment are necessary before effective care can be given. In this way health workers can avoid seeing all people as alike, and identifying different modes of behavior or health beliefs, and attributing them to a specific cultural group (Leininger, 1978).

In the past, behavior regarding health and illness was described from the professional's perspective. Recent interest

in discovering the client's view of illness is challenging health workers to understand more fully what clients know and understand about their illness, how they desire to be helped, and ways in which the health care provider can help them. This approach recognizes that clients are capable of telling us about their illnesses and able to give us clues about how to help them. Health care providers must give careful consideration as to how the client's view their illness in order to obtain the realistic goal of helping the client them. Gaps between the client's and the health care provider's viewpoints can cause difficulty in communication and the establishment of a therapeutic relationship. The client may find it difficult to understand the behavior of the caregiver and may silently refuse to return for follow up care (Brownlee, 1978; Leininger, 1978; Spector, 1985).

Conclusion

Practitioners today are comfortable with technology. They have eradicated many communicable diseases and can transplant organs. However, one deficient area is understanding and working with people of different cultural and economic backgrounds. It is Leininger's (1978) contention that once we make cultural factors an integral part of our mode of thinking and practice we will more adequately respond to client's health needs. Whether cultural differences are of a major or minor magnitude, it is up to the practitioner to assess them and determine appropriate responses. It is erroneous to make broad generalizations about people's health needs, and health care providers should be aware

of subtleties in cultural differences, as well as regularities and irregularities in particular cultures.

A culturological assessment is a systematic appraisal of individuals, groups, and communities relating to cultural beliefs, values, and practices. The goal of a culturological assessment is to determine explicit client needs in order to design culturally sensitive interventions. It is broad, comprehensive, and deals with ways of living. It is an appraisal of a particular cultural value and how it relates to cultural practice; i.e. a client may value independence but is not able to practice it because he lives with his father, therefore a conflict arises (Orque, Bloch, & Monrroy, 1983). It can be used to discover degrees of differences and similarities in cultural variations among individuals, groups, or communities.

Human beings are unique, possessing cultural characteristics which shape and guide their behavior in different ways. The roots of cultural influence are deep, widespread, and can be found in the behaviors of a group. They require careful assessment to determine. Culturological assessments are an important new area for health care providers (Orque, Bloch, & Monrroy, 1983; Tripp-Reimer, 1984). An example of a culturological assessment can be found in Orque, Bloch, & Monrroy's *Ethnic Nursing Care: A Multicultural Approach*. For safe effective care to be given to our clients, these cultural differences must be identified, acknowledged, and addressed.

PART II: MEXICAN AMERICAN-CULTURE

By

Debra A. Erickson- Owens, Major, United States Air Force,
Nurse Corps

Mexican-American Objectives

At the completion of this portion of the module the reader will be able to :

1. Identify the unique demographic characteristics of the Mexican-American culture which necessitates an increased awareness by health care providers.
2. Discuss the philosophies of greatest contrast between the dominant United States culture and the Mexican-American culture.
3. Identify the key cultural factors influencing pregnancy, labor and delivery, postpartm, newborn, and interconceptional care.
4. Discuss the implications for care of the Mexican-American client.

Introduction To Mexican-American Culture

Approximately 11.8 million persons of Mexican origin or descent live in the United States (U.S.), making Mexican-Americans the second largest minority in this country (Alvirez, Bean & Williams, 1981; Parade Magazine, 1987). In March 1987, the U.S. Census Bureau reported the Hispanic population (62.6% of that population is Mexican-American) is increasing at a rate five times faster than the non-Hispanic population within the U.S. (Parade Magazine, 1987). Mexican-American's (also known as Latinos, Spanish Americans, Chicanos or Americans of Spanish descent) have a fertility rate 50% higher than any other cultural group within the U.S. (Gonzalez-Swofford, 1983; Tamez, 1985). This rapidly expanding Mexican-American population, with a high fertility rate, is reflected within the Air Force community and health care providers will need to recognize and meet the childbearing health needs of Mexican-American women.

Within the U.S., the Hispanic population contributes to a relatively high perinatal mortality rate. A study done in Colorado identified neonatal deaths were three times higher in populations with Hispanic surnames (Bullough & Bullough, 1982). Reasons cited for this appalling statistic were: (1) poor involvement in current prenatal care programs (late entry into care with infrequent prenatal visits); (2) inadequate living conditions before and after delivery; and (3) poor health of hispanic women, including poor nutrition (Bullough & Bullough,

1982; Martinez, 1983). Cultural beliefs and practices may play a significant role in influencing this high perinatal mortality rate. Providers must learn to understand these cultural beliefs which have been passed from generation to generation for centuries, to offer ways for clients to adjust and adapt behaviors in order to cope with the world around them (White, 1985). With a better understanding of how Mexican-American woman thinks about childbirth, the provider can help the woman realize the importance of appropriate health practices without discrediting her beliefs and practices (Gonzalez-Swofford, 1983).

Traditionally, Mexican-American women view pregnancy as a condition requiring little or no prenatal care (Tamez, 1985). The women focus on the postpartum period and perceive this to be a time of greatest vulnerability (White, 1985). The dominant American culture, in contrast, views pregnancy as a condition with inherent risks requiring prenatal care to insure healthy outcomes of mother and baby. In the dominant culture, postpartum is seen as a period of lesser importance (Jensen & Bobak, 1985; Martinez, 1983). Such contrasting childbirth philosophies can lead to conflict. Conflict can be minimized and effective care maximized when providers increase their awareness and sensitivity to Mexican-American cultural beliefs and values (Murillo-Rohde, 1981).

The provider must keep in mind that each Mexican-American woman is unique. Generalizations made about her culture are used to identify common lifestyle patterns based on traditional

beliefs and customs. Stereotyping is not intended. Each woman individually expresses her culture based on influences from past events, her family, socioeconomics and the degree of enculturation within an american lifestyle (Gonzalez-Swofford, 1983; Stenger-Castro, 1978).

The focus of this section has two major themes. The themes are (1) philosophies unique to Mexican-American women and how they affect childbearing and (2) implications for OB/GYN care given to Mexcian-American women by Air Force care providers.

The philosophies of greatest contrast between the dominant U.S. culture and the Mexican-American culture are (1) religion, (2) health and illness, (3) family, (4) the role of men and women, (5) traditional folk medicine, and (6) Anglo modern medicine (Anglo will be used in this text to indicate dominant American culture).

Philosophies Unique To Mexican-American Women

Religion

Most Mexican-Americans are devout Catholics although older Mexican-Americans are more likely to have more religious beliefs than the younger population (Gonzalez-Swofford, 1983; Kay, 1978). Their God, creator of the universe, is all powerful. God controls all good and evil. This attitude fosters a fatalistic view that one can do "little, if anything ... about the course of one's life" (Samora, 1978, p. 67). Living a good life by submitting to and accepting God's will, with frequent prayer, should bring God's beneficence in the reward of good health.

Illness and suffering result as punishment for disobeying God's word. The impact of religion on the culture can not be underestimated-it serves to explain many everyday occurrences and is central in this culture's concept of health and illness. Traditionally, women didn't participate in prenatal care because they believed "God sends babies and sometimes He takes them away"; the will of God could not be challenged (Kay, 1978, p. 103).

Health and Illness

Health and illness are important value orientations in life. Health is a state of being: one is either ill or well (Samora, 1978). Illness/wellness is not under the individual's control but under the direct control of God (Gonzalez-Swofford, 1983). Wellness is being free of pain and traditionally Mexican-Americans may believe that women experience more pain than men. Being in good accord with God is believed to help maintain good health (Wang, 1976). Illness is associated with discord from God as a form of punishment. The concept of preventative health care doesn't exist in traditional Mexican-American culture because individuals have no control over their lives (Samora, 1978).

In 1959, Clark classified Mexican-American illness into one of the following categories: (1) Hot/Cold Imbalances (2) Dislocation of Internal Organs (3) Disease of Magical Origin (4) Disease of Emotional Origin and (5) Standard scientific disease with no recognition of the Germ theory. The category of illness influences the mode of treatment the individual will select,

whether that is traditional folk medicine or Anglo modern medicine.

Family (Familism)

According to Murillo (1978, p. 10), "The family is the single most important unit in life". The family unit becomes the responsible unit for continuing the species and orienting the individual to their social role. "The family creates and maintains a common culture and promotes the physical, mental and social development of each member" (White, 1985, p. 21-22).

Beginning a family is started as soon as possible after marriage and traditionally four children are desired (Kay, 1978). The "typical" family includes the nuclear family (husband, wife and children) and the extended family (grandparents, aunt , uncles and Godparents or Compadre)s (Ehling, 1981). In the traditional family, the father is the head of household and is the sole breadwinner while the wife has the responsibility as caretaker of her husband and children. Her focus is on her family and there is a tendency for the woman to acculturate slower into the dominant culture because of limited contact with others outside the family. Family needs and demands have top priority and the family is the primary source of material and emotional support for Mexican-Americans. Membership within the family heavily influences an individual's lifestyle. Many Mexican-Americans will not make decisions without family approval. Tamez (1985) stated that family approval and encouragement may be needed even before a woman will seek

prenatal care. Many Mexican-Americans share a firm belief that personal or family affairs will not be discussed outside the family and to do so is a disgrace to the family strength (Murillo-Rohde, 1981). When advice is sought, the member must first turn to the family (Alvirez, Bean & Williams, 1981). The family is the "core of its members thinking, behavior and center from which his view of the rest of the world extends" (Murillo, 1978, p. 10).

Role of Men

Machismo or maleness is the role most often associated with Mexican-American males, although this image appears to be in transition. Traditionally, the man is the autocratic head of household and very few decisions are made without his approval (Murillo, 1978). His ability to father children is one measure of his virility, and Mexican-American society accepts his flirtations with women other than his wife (Bullough & Bullough, 1982). The "macho" man considers it a matter of pride to afford to have a wife stay at home and care for the family (Ehling, 1981). Conflict arises when some men have difficulty understanding a woman's desire to work outside the home (Ehling, 1981). Enculturation is affecting the traditional machismo role as evidenced by shrinking family sizes and the larger role women now play in decision making within the family, yet machismo continues in varying degrees within today's Mexican-American families.

Role of Women

The traditional Mexican-American woman is devoted to her husband and children. She is a nurturer, serving her husband, obeying his decisions, supporting his actions and caring for the home and children. Frequently, her personal needs fall secondary to the needs of her family. The family defines her social role-it is the center of her existence (Murillo, 1978). The woman is dependent upon her husband who is the family representative to the outside world (Tamez, 1985).

Many Mexican-American women of today are challenging this traditional role yet some still abide by these traditional values unique to their culture and refuse to join the trend of women in the dominant American culture (Ehling, 1981). Regardless, most women are totally responsible for childbearing and contraception with usually insufficient or poor information regarding their bodies and reproduction (Kay, 1978). At a very early age, children are taught to consider the reproductive process as private (Ehling, 1981). If advice is sought regarding these "private" issues usually other female family members will provide the necessary information. The Mexican-American preoccupation with privacy places high value on modesty and dignity. When Mexican-American women confront Anglo care providers, who are often male, there is a tremendous sense of fear, embarrassment and shame (Mardiros, 1984). Modesty can act as a barrier to women seeking prenatal care, resulting in a reluctance to submit to care which involves private body areas (Wang, 1976). Enculturation may affect these attitudes as more younger women

challenge the traditional Mexican-American values (Ehling, 1981). Women are seeking more employment outside the home and are more active in regulating family finances and activities (Clark, 1959). Strictly separated sex roles are gradually disappearing and women are beginning to reject the idea of the superior, authoritarian male; conversely husbands are participating more in the care of the home and children (Tamez, 1985). Kay asked husbands the desirable characteristics for a good wife and they responded that "she must take care of the children, but she should also be understanding, considerate and affectionate"; fidelity and submission were rarely mentioned (Kay, 1978, p. 96).

Traditional Folk Medicine

Traditional folk medicine and beliefs share a common bond with Mexican-American religious beliefs and values, both evolving around the concept of good and evil. Mexican-American ancestors, influenced by the teachings of Hippocrates and 16th century Spanish explorers, devised a set of beliefs to classify folk disease (Clark, 1959). The diseases were classified as natural or supernatural and occurred when God was displeased with an individual's behavior (Holland, 1978). These classifications have been passed from generation to generation and their influence on health behaviors depends on a person's locale, degree of urbanization, isolation from Anglo communities and the degree of enculturation into the U.S. culture (Martinez, 1983; Clark, 1959). Studies of pregnant Mexican-American women revealed the women had limited belief in the traditional folk

health system yet still based some self care treatments on the teachings from their previous generations (Gonzalez-Swofford, 1983; Koster, 1986).

Lay care providers, Curanderos or Curanderas, evolved from a need to treat the more "severe" folk illnesses. The Curandero(a) is often a well known member of the local community and the people of the community will seek care for such illnesses as Mal de Ojo (Evil Eye- a person's unintentional admiration of a body part of the victim), Susto (Magical Fright-fright caused by a natural phenomena such a loud noise of thunder) or Empacho (food blockage of the intestines) (Wang, 1976). The Curandero(a)'s treatment may consist of (1) understanding and reassurance, (2) administration of herbs, (3) topical application of linaments and oils with herbs, (4) Sobaños or massgae techniques, (5) Ventosas or cupping, (6) regulation of a "Hot-Cold" diet, and (7) magical cures (Clark, 1959). The Curandero(a) is a very powerful individual, a fact often overlooked by Anglo care providers. When the Curander(a) is unable to cure with folk medicine, the patient may turn to Anglo health care for medical support but continues with the trusted Curadero(a) for emotional/spiritual support. This may result in a conflict of treatment causing ineffective care for the client's problem.

Anglo Modern Medicine

The Mexican-American patient may be reluctant to seek care from Anglo care providers because of (1) language barriers, (2) fear of discrimination, (3) fear of being ridiculed, (4) beliefs

that reinforce a strong family can deal with its own problems, (5) modesty and fear of invasion of privacy, (6) cost, (7) insistence by the Anglo system for promptness and (8) insensitivity of care providers to folk illness and treatment (Clark, 1959; Martinez, 1983; Martinez, 1978; Murillo-Rohde, 1981). Mexican-Americans often approach Anglo medicine with suspicion and mistrust and fear the provider will lack sensitivity and understanding (Murillo-Rohde, 1981). Many feel the provider will not understand the Mexican-American folk beliefs/treatments and anticipate ridicule if they were to discuss their traditional practices (Stenger-Castro, 1978). Mardiros (1984) identifies language barriers as another factor which fosters distrust between patient and provider. She notes that staff frequently belittle patients with little or no English skills and he/she can not follow the recommendations and treatments of the provider. Lack of cultural sensitivity and poor language communication interferes with effective care and helps to develop attitudes of racism and stereotypes (Murillo-Rohde, 1981). When Mexican-American women do not seek early prenatal care, some providers will label all Mexican-American women as uncaring, lazy or ignorant (Jensen & Bobak, 1985). Care providers frequently are frustrated when Mexican-American women will not make decisions yet the providers are unaware that the woman traditionally seeks family approval before arriving at a decision (Murillo, 1978). The Anglo providers who appear to be the most successful in caring for Mexican-American patients try

to (1) increase their awareness of the Mexican-American culture and its folk beliefs, (2) communicate in the patient's language (by themselves or through the use of an translator), (3) offer understanding and sympathy, not appearing rushed, (4) recognize the Curandero(a)'s role in health care, (5) give clear rationale for treatment, (6) include the family in decisions, and (7) respect the Mexican-American attitudes's towards privacy. The Anglo method of medicine will best be sold to the Mexican-American culture by repeatedly showing competence, caring and curing (Clark, 1959).

Mexican-American Women's Attitudes Toward Childbearing Pregnancy

Pregnancy is welcomed soon after marriage (Kay, 1978). Children are a highly valued part of the Mexican-American family (Ehling, 1981). According to White (1985), the Mexican-American women in her study viewed pregnancy as (1) a normal life process, (2) a well condition, (3) a time of good body image, (4) enhancing status within the community--motherhood is highly respected, and (5) a time for coping with the body changes with minimum complaints. Extended family are used extensively during pregnancy. When a woman first discovers she is pregnant, she turns to the women in her family (mother, sister(s), and an abuela or grandmother) who are more experienced in the folk beliefs and traditional practices relevant to childbearing (Koster, 1985; Tamez, 1985; White, 1985). If separated by geographic distance, the pregnant woman may confide with her

mother-in-law or friends (White, 1985). The traditional advice given is a set of childbearing rules passed through the generations as a way to protect the woman and child during pregnancy and birth (Kay, 1978). Many contemporary Mexican-American women are skeptical of the traditional beliefs and can give little explanation as to their usefulness, yet often when pregnant, these women follow some or all of the practices as a way to adapt to the many changes occurring with pregnancy and birth (Kay, 1978); White, 1985). Jensen & Bobak (1985) further note that these pregnancy rules are created to (1) prevent maternal illness from pregnancy induced imbalance states, (2) protect the vulnerable infant, and (3) protect other persons from illnesses caused by a woman in the state of pregnancy. Mexican-American childbearing rules provide lay guidelines for prenatal care.

Anglo medicine's prenatal care is a new concept for Mexican-American women. Traditionally these women did not seek prenatal care because (1) they do not feel ill, (2) they do not consider pregnancy capable of causing severe illness, (3) they do not consider it important, and (4) they cannot affect the outcome because they believe that God has control (Kay, 1978; Martinez, 1983; White, 1985). This belief system sharply contrasts with dominant American culture, which expects each pregnant woman to participate in prenatal care. The Mexican-American woman's participation in prenatal care is influenced by (1) family acceptance and practice, (2) socioeconomics, (3) availability of

transportation, (4) language barriers, and (5) clinical site-waiting time, type of providers and acceptance of children (Jensen & Bobak, 1985; Martinez, 1983). The March of Dimes (1982) reports these influences result in Mexican-American women beginning prenatal care later and receiving fewer visits as compared to the dominant population. Although this is documented, most women feel they receive adequate care (Martinez, 1983). Health care providers must be sensitive to the Mexican-American childbearing rules and explore ways to effectively bring these women into prenatal care sooner and more often.

The common traditional pregnancy beliefs focus on (1) nutrition, (2) activity, (3) locus of control, (4) discomforts and relief measures, and (5) environmental effects. Pregnancy is considered a "hot" state and therefore it is recommended that hot foods and medicines (i. e. chilies, citrus fruits, beef, cereals, milk, liquor, aspirin, and penicillin) be avoided. Cool or cold foods and medications (i. e. bananas, avocado, chicken, milk of magnesia and antacids) are recommended in order to refresh and balance the "hot state" of pregnancy (Gonzalez-Swofford, 1983; Murillo-Rohde, 1981). White (1985) noted that many of the Mexican-American women in her study did not remember which foods were hot or cold, and therefore practiced very little dietary restriction in pregnancy. In a study done by Danneskiold (1980) to examine the nutritional intake of Mexican-American women during pregnancy, it was found that diets were lacking or deficit in all nine nutrients of the Recommended Daily Allowances (RDA).

Particularly low intakes were found in Vitamin C foods, leafy green vegetables, and milk products. The decreased milk intake was not directly related to lactose intolerance, but perhaps a traditional belief that milk made larger babies and a more difficult birth (Danneskiold, 1980; Kay, 1978). According to several sources, women of Mexican-American culture do believe in pregnancy iron and vitamins, but usually discourage the use of other medications (Kay, 1978; Koster, 1986).

Activity (other than lifting heavy objects or doing heavy housework) is encouraged during pregnancy (Kay, 1978; White, 1985). In fact, it is believed that continued activity will ensure a short and easy birth. Walking is the single most universal birth tradition practiced. The women feel walking will prevent the fetus from growing too large. Sexual activity is encouraged throughout the pregnancy in order to keep the vagina well lubricated (Kay, 1978). The only activities generally recommended to avoid are crossing legs, sitting in a tailor's position, and reaching above the head; ~~all because these~~ activities may increase the risk of cord entanglements (Kay, 1978). The locus of control is usually more external for Mexican-American women when compared with Anglo women, who have a more internal locus of control. Many Mexican-American women believe that their actions have little influence on future outcomes. Often the woman has little understanding in the role she plays in assuring a healthy pregnancy outcome (Martinez, 1983; White, 1985).

Discomforts of pregnancy are usually relieved with home remedies passed down through generations. They include Chamomile Tea for relief of nausea and vomiting, easy labor, and placental separation. A mixture of water and baking soda is used to relieve heartburn. Flour and water, or flour and lemon juice mixed together are used to decrease nausea. Avoiding sitting too long on a cold surface is thought to reduce hemorrhoids as will drinking a herbal tea of rose petals or laundry bluing. Southwestern Mexican-Americans may make a blood pudding to treat anemia. Varicose veins, leg cramps, and back trouble can be avoided by not going barefoot (Gonzalez-Swofford, 1983; Martinez, 1983; White, 1985). According to White (1985), seven out of ten women in her study practiced at least one of these discomfort relief measures during pregnancy.

Control of the pregnant woman's environment is important. Temperature extremes (i. e. night air, cool drafts, or sunrays through glass) should be avoided. Mal Aire (bad air) can cause pain and cramps. Exposure to eclipses or moonlight can be responsible for birth defects (i. e. cleft palate/lip). Earthquakes or severe emotional distress may cause preterm labor, miscarriage, cord entanglements, or a breech presentation. Susto (severe fright) can cause a birthmark on the developing fetus (Clark, 1959; Kay, 1978; Martinez, 1985; White, 1985). Awareness of such common traditional pregnancy beliefs can help the provider be more sensitive to the worldview of Mexican-American women. Yet the provider must be aware that each woman is unique;

whether or not these beliefs are adhered to will be influenced by (1) individual personality, (2) economics, (3) educational level, (4) family influences, and (5) amount of enculturation (Koster, 1986). The provider should also be aware of cultural prevalence of disease which puts the Mexican-American pregnant woman at risk. In March 1987, the Center for Disease Control (CDC) reported that of the 2159 women in the U. S. diagnosed with Autoimmune Deficiency Syndrome (AIDS), the highest occurrence was among Hispanics and Blacks (Star et al, 1987). Women with Mexican-American surnames are more likely to suffer from rheumatic fever, pneumonia, and influenza. There is also an increased incidence of diabetes mellitus among Mexican-Americans, possible due to a high carbohydrate diet, genetic influence, or lack of medical care (Bullough & Bullough, 1982). This information may guide the provider's screening procedures during the prenatal period.

Labor and Delivery

Val Koster (1986), states that the Mexican-American women in her study described labor and birth as a normal process and believed that a "natural" birth was preferred over a medicated, interventive birth. It is believed that labor pain should be endured with patience and is considered a normal part of birth (Kay, 1978; White, 1985). Pain will frequently be expressed by soft moans and groans as a way to let others know of their suffering (Murillo-Rohde, 1981).

Traditionally women were encouraged to walk until the moment of birth (Kay, 1978). Food and chamomile tea may be offered throughout labor as a way to improve uterine function (Kay, 1978; Koster, 1986). Younger children are not allowed to attend the birth. Medications and anesthesia at birth are generally discouraged and episiotomies are not routinely performed (Koster, 1986). The placenta is burned after birth to avoid childbirth cramping (Kay, 1978). The laboring woman feels much more comfortable when surrounded by family members (especially her partner and mother). When admitted to the hospital, the woman may feel frustrated with hospital restrictions placed on the number of visitors allowed in the labor and delivery area. Usually the woman wants a large number of family members to provide support (Bullough & Bullough, 1982; Koster, 1986; Wang, 1976).

Postpartum (La Dieta)

La Dieta is traditionally the most important time during the childbearing. It is considered "critical in the overall health of the mother" (White, 1985, p. 65). La Dieta is considered by Mexican-American women to be the time of greatest vulnerability to infection and special precautions are traditionally followed until the woman recovers from birth. Most women now ignore many of the traditional practices but a few beliefs continue and are followed (Ehling, 1981). The period of La Dieta is the first 40 days postpartum. The new mother stays in bed for approximately seven to 14 days, and then increases her activity gradually

(avoiding heavy lifting or housework). Her mother usually comes to stay during this time and provides physical as well as emotional support. Bathing is discouraged but special attention is given to perineal hygiene. Sexual intercourse is forbidden for the first 40 days and birth of another child within one year is frowned upon. The woman may wear a faja (a tight abdominal binder) during La Dieta as a way to quicken involution. Diet, based on hot and cold foods, has an important role in recovery and is thought to prevent major illness during the postpartum. Special precautions are taken to avoid hot foods (i. e. beans, broccoli, citrus fruits, chilies) in order to restore a "hot-cold" balance. The ideal diet consists of Atoli (corn mush), milk, eggs, tortillas, chicken, and cooked cereals. This diet may continue until the infant weans. The woman usually remains indoors during La Dieta in order to prevent exposure to cold air which might cause chilling of the womb. Chilling of the womb is associated with infertility, frigidity, subinvolution, and afterbirth cramping. Medications during La Dieta are limited. Milk of Magnesia is usually taken on day three postpartum, and calcium supplements are not uncommon. Aspirin is believed to liquify the mother's blood and is thus avoided. A home remedy of olive oil and manzanilla tea is used to treat afterbirth cramps. When the convalescence is complete, the new mother will resume her normal duties, and her mother will return home (Clark, 1959; Ehling, 1981; Kay, 1978; Koster, 1986; Murillo-Rohde, 1981; White, 1985; Zepeda, 1982).

Newborn

The birth of a baby is an exciting event for the Mexican-American family. The baby's birth is celebrated by the ritual of baptism. Family and friends are invited to welcome the newborn and Compadres or godparents are named to be the child's life sponsors. Boys are desired as the firstborn child to carry on the family name. Girls are considered "heartier" than boys and more resistive to newborn diseases. Circumcision is not an accepted practice and is considered unnecessary. The umbilical cord is symbolic in this culture and may be associated with magical power. The cord may be wrapped in an abdominal binder to prevent umbilical hernias, secure internal organs and prevent mal aire (bad air) from entering the infant's body, although it appears that this cultural tradition is losing popularity.

Traditionally breastfeeding was the feeding method of choice. Since colostrum was considered "dirty", the new mother started nursing on the third postpartum day and was supported by her partner and family. Beans, chili, garlic, chocolate and fresh fruit were avoided in the mother's diet to prevent empacho (stomach blockage) in the newborn. Recently, bottlefeeding has become the feeding of choice among Mexican-American women and early introduction of cereal is common. In this culture, mothers believe a fat baby equates with a healthy baby. Regardless, feeding is a very nurturing time for the infant and the infant is usually fed on demand while being held frequently to avoid crying.

The infant is felt to be vulnerable to many illnesses. Respiratory diseases are the leading cause of perinatal mortality and morbidity in Mexican-American infants. The speculated cause of this centers around lack of medical care and possibility a genetic influence. Often the mothers will "overdress" their infants to protect them from mal aire that can cause these diseases. Some of the traditional illnesses that can endanger the newborn are Pujos (grunting), Mal Ojo (Evil Eye) and Mollera (Fallen Fontanel). The Curandero(a) may be consulted for treatment prior to entry into the Anglo health care system. Immunizations are acceptable and parents usually comply and understand their importance. The child is considered to be a very important part of the Mexican-American family life (Bullough & Bullough, 1982; Clark, 1959; Ehling, 1981; Gonzalez-Swofford, 1983; Kay' 1978; Lasater & Montalvo, 1985; Murillo-Rohde, 1981; Tamez, 1985; White, 1985; Zepeda, 1982).

Interconceptional Care

Fertility rate is 50% higher in Mexican-American couples as compared with other ethnic groups. Families have traditionally had four or more children. Large family size occurs because of (1) machismo (show of male virility), (2) religious attitudes towards birth control, and (3) hembrism (femininity reinforced by fertility). If the woman wanted to avoid pregnancy she might pray, sneeze, stifle orgasm or jump numerous times after intercourse. Sex education on how pregnancy occurs and can be

prevented was unheard of. Sexual instruction was left to the husband who gained his information from his peer group. Changing cultural practices and the increased availability of birth control methods are now helping women to be more aware of and to have more control of their bodies. Couples realize using family planning can help limit family size and may help them escape the "traditional" poverty associated with large Mexican-American families. The methods currently used by couples are oral contraceptive pills, tubal ligation, coitus interruptus, rhythm and periodic abstinence. Women prefer to avoid barrier methods because of modesty and the "messiness" of foams/gels. Abortion is available but is not a commonly used form of birth control. Couples are now gaining awareness of their bodies and have options available to help plan family size (Alvirez, Bean & Williams, 1981; Ehling, 1981; Kay, 1978; Tamez, 1985).

Implications For Care

It is clear that Air Force care providers, whose origins are the dominant American culture, must understand and be sensitive to the unique beliefs and health care needs of the Mexican-American woman and her family. In understanding the implications of culture, language, traditional and religious value and beliefs, the provider will foster a relationship of respect and trust which is invaluable in the provision of effective care. Effective care during childbearing will help reduce perinatal mortality/morbidity and improve the outcomes of Mexican-American women and their infants.

Mexican-American women have the right to expect that their health care provider will meet their physical, emotional and cultural needs (Jensen & Bobak, 1985). It is reasonable to expect the provider will appreciate and respect the woman's cultural practices and beliefs with caring and acceptance. Providers should understand the worldview of the Mexican-American woman. In addition, the provider must assess each woman's traditional beliefs and evaluate the influence of enculturation on those beliefs in order to provide individual and effective care (Ehling, 1981; Mardiros, 1984).

The provider must be cautioned to avoid labelling and stereotyping Mexican-American women solely based on cultural background. The variations among Mexican-American women is enormous. The following recommendations are only to be used as general guidelines in providing care.

1. Speak in the language of the woman

The provider ideally should speak the language of the woman but this is not always possible. If the woman and provider do not share a common language then use of a translator, family member or member of the same cultural group is necessary. The provider must speak directly to the woman even if the translator is assisting, and must tell the translator that she/he is interested in all that the client says (Jensen & Bobak, 1985). The removal of the language barrier will improve communication and build a relationship of trust and value.

2. Approach with respect and caring

This includes accepting the client and her traditional values. It fosters a sense of dignity within the patient and encourages continued participation in the health care system.

3. Accept folk medicine and the Curandero(a)

Many providers discount the roles played by folk medicine and the traditional treatments provided by the Curandero(a). There has been minimal collaboration between Anglo providers and the Curandero(a) yet many women believe only the Curandero(a) can treat traditional illnesses (Mardiros, 1984). Knowing Mexican-American beliefs about folk illness and cooperating with the Curandero(a) may encourage early entry into prenatal care.

4. Be aware of religious influence

Mardiros (1984) indicates that religious permeates most aspects of the Mexican-American lifestyle. This influence is especially influential on family relationships, family size and contraception.

5. Expand educational programs

Some Mexican-American women have had insufficient education and are unfamiliar with and know little about their bodies (Kay, 1978). Educational programs must be developed or redesigned to educate women about their bodies, reproduction, prenatal care, labor and delivery, infant care, parenting, and contraception. The programs, to be effective, must accommodate the cultural and socioeconomic needs of the women. Available services, such as Women, Infants and Children (WIC), need to be publicized. Word of mouth and television are the most popular ways to spread

information among the Mexican-American community (Martinez, 1983). Classes must be taught in the language common to the woman and information should be current, realistic and useful. Offering education to the woman as well as her partner and family may result in better care compliance. Education should be at no or low cost through the agency where the woman receives her care. Offering transportation and/or childcare might improve attendance. Based on cultural values, instructors should be used who are older experienced women. These instructors will be seen as having more authority (White, 1985). Certified Nurse Midwives (CNM) may also enhance educational programs. The CNM is a specialist in education and counselling and often is viewed a non-threatening figure to Mexican-American women (Martinez, 1983).

6. Understand the importance of diet and its influence on nutrition

Provider knowledge and understanding of food preferences and the "Hot-Cold" balance of diet can enhance the woman's compliance with a nutritious diet. Counselling can include known diet habits and ways to meet the nutritional needs of pregnancy and lactation. Because the Mexican-American's diet was found to deficient in all nine RDA's, diet counselling should include foods to boost the RDA's, such as beans and cheese for protein foods and chilis or tomatoes for Vitamin C rich foods. Suggestions should be given for alternatives for non-milk drinkers. WIC and food stamps should be an offered alternative

for women who qualify. Providers should always remember to respect the ethnic preference for Mexican-American foods and tailor their nutritional counselling around those preferences while trying to increase the likelihood that women will view their diet behaviors as affecting the outcome of their baby.

7. Involve family members

The family has tremendous impact upon the Mexican-American woman. Seeking prenatal care, utilizing Anglo health care and following prescribed recommendations and treatments can be approved or disapproved by family members. Decision making may be delayed until the family can discuss and agree on the correct action to be taken. The health care provider must acknowledge the family and avoid excluding family members who at times appear to hinder or burden the provider-patient relationship (Ehling, 1981). Providers must identify and communicate with their patient's significant other(s). These peoples' opinions are the strongest influence on a woman's decisions about participation in prenatal care (Johnson, 1978).

8. Respect privacy and maintain modesty

The Mexican-American culture places high value on privacy and personal dignity (Mardiros, 1984). Some Mexican-American women find it embarrassing and humiliating to expose "private parts" of their body to strangers, especially male strangers. It is important to be sensitive to this cultural value and try to support privacy and modesty. Preferably a woman provider, such as a female CNM, will be available to provide health care for the

woman. Such care should be consistent throughout the prenatal and delivery period. A goal for effective care might be the preservation of modesty in order to establish a trusting relationship between the provider and the woman (Jensen & Bobak, 1985).

9. Prenatal screening

Certain diseases are more prevalent in one culture when compared with another culture. The provider's awareness of increased incidence of diabetes, rheumatic fever, pneumonia, influenz and AIDS in the Mexican-American population should alert him/her to take a thorough history and identify women at risk. A diabetes screen at 28 weeks gestation should be mandatory and earlier screen if family history warrants it. The woman's history should include questions about rheumatic fever and other family members should be consulted if history is unknown. Women should be identified if they have a high risk index for exposure to AIDS. If the woman complies by written consent, a test for AIDS should be offered.

10. Support the evolving role of the Mexican-American woman

Women, especially Mexican-American women, are experiencing confusion and conflict in today's society as they leave traditional roles. The Mexican-American woman enculturating into the American lifestyle experiences additional stress as she tries to break from traditional values. Thus, she lives within a bicultural world. The Mexican-American woman caught in the changing roles of women may experience chaos and a loss of self-

identification, which may be expressed as depression or acute anxiety (Murillo, 1978). These women need time to express their conflicts and providers must support and allow the woman to validate her own self image. At times, referral to a culturally sensitive counselor may be necessary to help the woman resolve her inner struggles.

PART III: ASIAN CULTURE

By

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Asian Objectives

At the completion of this portion of the module, the reader will be able to:

1. Define the term "Asian" according to the United States Bureau of Census.
2. Discuss the four key Asian philosophies.
3. Identify four common Asian values.
4. Identify the key cultural factors influencing health care and childbearing.
5. Identify unique Pilipino beliefs and values important to health care and childbearing.
6. Identify unique Korean beliefs and values important to health care and childbearing.
7. List the unique prenatal screening needs of the Pilipina and Korean client.
8. Discuss the implications for care of Asian (Korean and Pilipina) clients.

This section of the module focuses on Asian culture, specifically Pilipino and Korean culture. This area of focus was chosen due to the large number of Pilipina and Korean women seen in Air Force Ob/Gyn clinics . The use of Pilipina/Pilipino will be explained under the Pilipno section. It should be understood that the cultural beliefs and practices discussed cannot be universally applied to all Asian, Pilipina and/or Korean women. "Practices vary according to such factors as education, social status, how long the woman has been in the United States, and whether she lived in a city or rural area in her native land" (Hollingsworth, Brown & Brooten, 1980, p. 45.). The care provider may use this information as a base on which to build, plus additional information gained in using an individual cultural assessment.

The term "Asian" generally refers to all residents of the United States who themselves or whose ancestors came from Asian countries, including China, Taiwan, Japan, Korea, Vietnam, Cambodia, Thailand, and Laos" (Tien-Hyat, 1987, p. 269). The United States Bureau of Census has recently included immigrants from the Pacific islands, including the Phillipines, Samoa, and Guam. Because of the large number and diversity of the subgroups of Asian people, this paper will focus on general cultural issues common to the largest groups of Asians living in the United States-The Chinese, the Pilipinos, the Japanese, the Koreans, and the Vietnamese. Due to the large number of Pilipina and Korean

women seen in Air Force clinics, special attention will be given to these two subgroups of Asians. It is important to remember that although "Asian/Pacific people have been classified as one ethnic group by many researchers and census takers, and that many people presume that the culture of all Asian/Pacific people is the same, there are some similarities among these cultural groups, but there are also many differences" (Kubota & Matsuda, 1982, p. 21). By gaining an understanding, of the basic Asian philosophical tenets, one is better able to understand, if not able to accept cultural differences and behaviors.

Asian Culture

Asian Philosophies

"The major philosophical orientation of Southeast Asians is a blend of four philosophies: Buddhism, Confucianism, Taoism, and Phi. These philosophies have four common values that are strongly reflected in Southeast Asian cultures: (1) male authority and dominance; (2) saving face; (3) strong family ties; and (4) respect for parents, elders, teachers, and other authority figures" (Kubota & Matsuda, 1982, p. 21). Each philosophy will be explained below:

Buddhism

According to Buddhist philosophy, all existence is suffering. The continuation of existence and therefore suffering arises from desires and passions and the solution lies in the cessation of personal desires. It is the Buddhist belief that no being is limited to a simple existence, ending in death; all

beings are continually reincarnated. By understanding the causality of things-nirvana or enlightenment, ultimate salvation is achieved. Religious merits are achieved by doing good deeds, sharing, donating to the temple, and acts of generosity and kindness (Kubota & Matsuda, 1982, p. 21).

Confucianism

Confucianism has heavily influenced the moral values of Southeast Asia. "It focuses on the concepts of the moral personality, moral qualities are developed through cultivation of the personality (Kubota & Matsuda, 1982, p. 22). Confucianism emphasizes two main qualities in the moral personality: (1) humaneness, the attitude shown toward others, and (2) sense of moral duty and obligation, the attitude that people display toward themselves. Confucius set down the following three principles for social behavior, according to Kubota & Matsuda, 1982, p.22):

(1) Pattern of Obligation and Authority: Five relationships (inferior to superior)-son to father, wife to husband, younger brother to older brother, friend to friend, subject to ruler-form a system in which the pattern of obligation and authority in the family is projected into social and political relationships. A friend is to regard a friend as a younger or elder brother. In the family planning clinic, the Southeast Asian woman will almost always seek her husband's decision in choosing a birth control method. This authority should be acknowledged and respected.

(2) Man in Harmony with the Universe: The Confucian system places humans and their social and political life in relation to the universe. People are between heaven and earth, and human life has to be in harmony with the universe. This principle is reflected in the Asian's passive way of responding to new information. Rather than actively seeking new information they might quietly accept the information, not completely understanding what they need to know.

(3) Ancestor Worship: Confucianism in its classical form is concerned with the moral order of relationships. Confucius had a deep reverence for tradition and prescribed rites for ancestor worship. The most important of the rites is a communal meal, shared with the dead."

"Confucian principles of obedience for women are as follows: the four virtues of a woman are proper employment, proper demeanor, proper speech, and proper behavior. The three obediences are: to follow the advice of one's parents while a maiden; that of one's husband while a wife; that of one's children, when a widow. Thus, the woman's role is subservient throughout her life" (Kubota & Matsuda, 1982, p. 22).

Taoism

According to Kubota & Matsuda (1982) Taoism had its roots in the belief in the magical forces of nature. There are two opposing forces, negative (Yin) and positive (Yang). The interaction of these forces creates the course of all life,

material and spiritual. Harmony with nature is achieved through nonaction and the balance of Yin and Yang. Illness is believed to result from an imbalance.

Phi

Phi is a belief in spirits. These spirits can be dead relatives as well as spirits of animals or nature. There are good and bad spirits. In Korea, the birth spirit is seen as an old woman, the Birth Grandmother. To induce conception in an infertile or sonless woman, a shamin coaxes the Birth Grandmother into a gourd dipper filled with rice grain. The woman, who desires to become pregnant, must carefully carry the dipper of grain into the inner (women's) room and set it down; conducting the fertile seed into the womb (Kendall & Dix, 1987). One must be careful not to offend the spirits.

Cultural Beliefs That May Influence Health Care

There are three main groups of immigrants residing in the United States and the degree of assimilation into the Western model of health care is related to which group a client is aligned with. There are those individuals who immigrated greater than twenty years ago, new immigrants who have arrived within the last twenty years and finally, first and second generation American-born Asians. Immigrants born in Asian countries, especially in rural areas, may be strong believers in ancient folk medicine and health practices and continue to influence their immediate families. American born Asians may be oriented to Western medicine, but may continue to bow to the

pressures of their elders. For example, "one young pregnant Chinese woman who was a registered nurse, routinely followed her obstetrician's orders, but at the same time, under pressure from her mother and mother-in-law, ate special foods and herbs to insure birth of a healthy baby" (Campbell & Chang, 1973, p. 246).

Yin and Yang

According to Wang (1976, p. 13) it is believed "that health is the normal flow of energy, regulated by two opposing forces of the universe, the Yin and Yang." Yin stands for the negative forces such as darkness, female, death, cold and emptiness. Yang stands for the positive forces such as light, male, hot, fullness and life-creating. "In the human body, the skin or external parts are Yang; the interior is Yin. The hollow organs are Yang and the solid organs are Yin. The theory is based on the assumption that organs within the body produce energy which circulates through the body in a 24 hour cycle. A disturbance in the flow of energy and in the balance of the two forces results in disease and disorder" (Wang, 1976, p. 13). An excess of Yang causes fever, dehydration, irritability and illness. An excess of Yin causes colds, nervousness, apprehension and gastric disorders. Wellness is achieved by regaining the balance of Yin and Yang through herbs, foods, medicines, rest or other specified activities.

Belief in Traditional Medicine

When an Asian person is ill, he/she may go to a Western doctor or to a practitioner of Asian medicine; or he/she may see

both. The Asian practitioner may be an acupuncturist, an herb pharmacist or an herbalist. The treatments may overlap each other. Some clients believe that there are certain diseases/illnesses that require Western medicine and others that do not. Tuberculosis requires Western medicine, while skin and blood disorders do not. It is important for the care provider to carefully assess previous and concurrent treatments. It is also important for the care provider to understand the benefits of some nonWestern treatments and accept the clients choice in which treatment to follow. For example, Campbell & Chang (1973) report a case of a diabetic woman who refused to continue taking her oral hypoglycemic medication and started taking a medicine prescribed by her herbalist. Her urine tested negative and she had no other apparent problems related to her diabetes.

Western medicine is thought of as "shots that cure" (Kubota & Matsuda, 1982, p. 24). A client expects a shot or pills when he/she visits a clinic. If no pill or shot is given, careful explanation must be given as to the rationale so as not to cause the client to doubt whether adequate care was provided. If pills are given, it is important to carefully discuss the treatment course. A herbalist provides a one dose cure; not a continuous maintenance. For example, in the case of antibiotic treatment for an infection, detailed instructions must be given for the course of treatment. The client may feel better and stop taking the pills before the full course of therapy, if no rationale is given as to why the full dose is needed.

Respect for Authority Figures

Health care providers are automatically given respect because they are seen as individuals with knowledge. People of Asia show respect to age and knowledge. Most Asians are sensitive and formal. Small talk on the providers part is necessary before the client is comfortable discussing health and illnesses.

The Asian client can be predicted to be a less assertive consumer. He/she will generally not spontaneously ask questions because of respect for the professional. It is therefore, important that the care provider be assured that the client understands. Questions should be encouraged and instead of asking yes or no questions, open ended statements are best. For example, "Could you tell me when you will take the medication, under what conditions?" If a client does not understand, he/she can protect his/her own self-esteem by concealing, through passivity, his/her own ignorance; and he/she believes that he/she can protect the health care provider's status by concealing disagreements or incomplete understandings from him/her, by appearing compliant or obedient (Muecke, 1983).

Saving Face

Saving face is a major and basic part of many Asian cultures. It is important not to place the client in an awkward or embarrassing situation, whenever possible. Children are encouraged to develop the desired and acceptable behaviors of modesty, industry, and respect toward the elderly and authority

figures, because these qualities enhance the family name. They must avoid behaviors which might bring shame to themselves and the family. Timidity, shyness, embarrassment, and sensitivity are also desired qualities which decrease the chances of bringing shame to the family. One way shame can be incurred is when a debt is not repayed or the person to whom the debt is owed, refuses payment. For example, if a care provider refuses a gift from a client after delivery of a child, a debt may still be owed in the eyes of the client. Shame is brought to the family.

Male Domination and Authority

It is necessary to recognize that male dominance prevails in most situations. A wife will want her husbands input/permission for many decisions. It is important to accept a wife's wish to have her husband make decisions for her. She, of course, needs counselling and teaching. If she comes to the clinic alone, she may be unwilling to make a decision without discussing matters with her husband, which should be respected.

Family Involvement

Asian families are extended families, and decision making is often a family affair. An Asian client is very much a part of his/her family. As a result, family members should be included in health teaching, decision making and care provision. Neighbors and friends may be regarded as family by the client and should be included if desired by the client. When in the hospital, a family member may wish to stay with the client most

of the time and other family members may bring in food. This should be accepted unless contraindicated.

Modesty

A strong cultural characteristic of many Asian clients is shyness and modesty. The female client may prefer a female care provider because she and her husband prefer she not be attended by a man. Pelvic exams are seen as an intrusion of personal privacy. Hospital gowns may be a special threat to modesty. (Nelson & Hewitt, 1983, p. 11-12). Whenever possible, female attendants should be available to decrease the sense of loss of modesty.

Crisis Orientation

Many Asian immigrants seek health care only when they are seriously ill. This was also their behavior in their homeland, where physicians, hospitals and clinics may not have been readily available. This was especially true in rural areas. Health care providers need to reinforce the need for followup appointments.

Diet & Nutrition

Food is thought to play a part in cause and treatment of diseases. When food is metabolized it becomes either a cold or a hot energy source. Too much of either can cause illness. Illnesses caused by excess hot (Yang) are treated with cold foods and illnesses caused by too much cold (Yin) are treated with hot foods. For example, "the common ginger root is believed to be a hot food and is used to strengthen the heart (Yang organ) and to

prevent and treat nausea and dyspepsia (Yin excess disorders)" (Campbell & Chang, 1973, p. 248).

Most Asians, like any other groups of people, have definite food preferences based on cultural eating patterns. The care provider needs to be aware of food patterns so that therapeutic diets are compatible with the client's beliefs and preferences.

It is important to work with clients in order to increase their compliance with dietary programs. If a client is in the hospital, relatives can bring in foods from home which can be substituted for hospital foods. This takes in to account both the food preferences of the clients and respects the belief in Yin and Yang causality and treatments.

Body Image

" Notions of body image that are widespread among Southeast Asians but uncommon among many Americans include reverence for the head, dispassionate acceptance of the female breast as the natural means for infant sustenance, and extreme privacy of the lower torso. The human head is regarded as the seat of life and therefore as highly personal, vulnerable, honorable, and untouchable except by close intimates" (Muecke, 1983, p.435). In order to avoid undue anxiety, explanation of rationales for procedures involving the head should be made. Avoidance of touching an infant's head or starting intravenous lines in the head is suggested unless absolutely necessary.

"The area of the body between the waist and knees is almost never exposed, even in privacy, by anyone other than young children. The loose hospital gown, or physical examination of the genital area can be deeply humiliating to the Southeast Asian patient" (Muecke, 1983, p. 435). When a pelvic exam is medically necessary, the client may wish her husband to be present; if possible the provider and interpreter, should both be female.

Attitudes Toward Childbearing

Pregnancy

"Prenatal care as we know it is a phenomenon of Western medicine. The Western biomedical model of care encourages women to seek prenatal care as early as possible in their pregnancy by visiting a physician or clinic" (Jensen & Bobak, 1985, p.67). Visits usually follow the systematic sequence of an initial visit followed by monthly, then weekly visits. During the visits, blood pressure, weight, blood and urine tests are done, as well as teaching related to nutrition, rest, activity, and fetal and maternal development. There is also usually information given about prepared childbirth.

This model may not be familiar to many Asians and may also seem very strange. Even if prenatal care is familiar, some practices may conflict with the client's cultural practices and beliefs. "Because of these factors and others, such as lack of money, lack of transportation, and poor communication on the part of health care providers, many groups do not participate in the prenatal care system, and their behavior may be misinterpreted by

nurses as uncaring, lazy, or ignorant" (Jensen & Bobak, 1985, p. 67).

For many cultural groups, pregnancy is considered a normal process. Health care providers may only be seen as necessary in times of illness. Even if problems of pregnancy do develop, they may be seen as normal by the client. Jensen & Bobak (1985, p. 67) note that " Thai women do not perceive weakness, fainting spells, palpitations, tremors, and diarrhea as abnormal."

"Although pregnancy is considered normal by many, certain practices are expected of women of all cultures to ensure a good outcome. Prescriptions tell women what to do, and proscriptions establish taboos. The purposes of these practices are to (1) prevent maternal illness from a pregnancy-induced imbalanced state, (2) protect the vulnerable infant, and (3) protect other persons from illness caused by a woman in a state of imbalance. Prescriptions and proscriptions ... are related to dietary practices, clothing, activity and rest, sexual activity and emotional response" (Jensen & Bobak, 1985, p. 67).

Nutrition

Women in most cultures are encouraged to eat a normal diet. The key is knowing what a normal diet is for the client. For example, "Southeast Asian women have rice and fish as basic foods, with supplements of vegetables, poultry, meats, eggs, and fruit depending on the season and family wealth" (Jensen & Bobak, 1985, p. 68). Fresh milk products are not usually consumed.

Among many Asians, herbal teas, such as ginseng, may be used in early pregnancy to strengthen the womb.

Food taboos are common. For example, many women avoid soy sauce in the belief that it will make the baby's skin dark. Shellfish may be avoided to prevent the formation of allergies in later life. Some women refuse iron supplements because they believe that iron will make the bones harder and delivery difficult. Food cravings during pregnancy are often considered normal in many cultures and must be satisfied for a variety of reasons.

Rest and Activity

The practices related to rest and activity vary tremendously. According to Jensen & Bobak, (1985) many groups encourage women to be active, to walk and engage in normal activities. Other groups believe that inactivity provides protection for the mother and child. The mother is encouraged to rest and await the delivery. This should not be seen as laziness or noncompliance on the part of the provider.

Labor & Birth

Concerns related to the intrapartum period focus on: (1) who is present during labor and delivery; (2) the position assumed during delivery; and (3) the management of pain. Many Southeast Asians prefer a female relative as well as care provider be present in labor and delivery. Some women prefer their husbands be present and others would be embarrassed if they were present. Some feel that the husband would be polluted by the woman's blood

if he were present. It is important to determine who the woman desires to be in attendance.

The lithotomy position is a Western design. Many Southeast Asian women prefer a squatting position. Others prefer ambulating and side lying. Again, it is important to determine what is more comfortable and acceptable to the woman in labor.

Pain management of Asian women in labor requires careful assessment. The women often exert great control and appear to be in great control. Crying out may shame or embarrass her family. Discussing with the woman and her support person that medication is available may increase the woman's control and decrease her chances of being shamed or embarrassed by calling out. Just because the woman is stoic does not mean that she is not in pain. The client is the best judge as to whether she needs pain relief.

Postpartum

The period of greatest conflict between Western medicine and Asian beliefs and practices comes during the postpartum period. The traditional postpartum period calls for a one-month period of rest during which the mother's diet and activity are directed toward decreasing the imbalance of Yin and Yang in the body. Delivery causes an increase in cold in the body and an increased susceptibility to cold entering the body. The pores are believed to remain open for thirty days postpartum, during which the cold can enter the body. Contact with cold items during the postpartum period is believed to cause wind to enter the body, resulting in

asthma, arthritis, and chronic aches and pains (Jensen & Bobak, 1985).

As a result the woman is forbidden to go outdoors or to take a shower or tub bath. Air conditioners and open windows are a source of fear to many Asian women. Fans are avoided. Water is always considered cold, whether it be for bathing or drinking.

Food is one way in which heat can be restored to the body. Temperature does not determine if a food is hot or cold. Green vegetables, fruits, meats, and fish are frequently considered cold. Rice, eggs, and chicken soup are hot foods. Chicken soup is also believed to help in milk production. Again water is avoided. The pitcher of water at the bedside will remain full. A hot substance, such as ginger, can be added to water to counteract its cold effects. Medications may be refused if nothing but water is provided to take them with. By encouraging family members to bring in appropriate foods, the mother will eat and be happier than trying to explain why she's not eating hospital food.

Many Asians believe that the postpartum period is one of a pollution state. A state of seclusion is necessary and the mother limits her activities. This is in contrast to Western theory which encourages early ambulation, early infant care, and early discharge from the hospital. The new mother is not lazy because she prefers to have her mother and/or the nurses care for the infant while she remains in bed. It is important for the hospital staff to allow visitors to help care for the woman and

infant. After a specific time period, usually after discharge from the hospital, special rituals may be performed and purity restored.

Pilipino Culture

Major Pilipino Philosophies and Beliefs

Pilipino Heritage

In order to understand the cultural patterns of a specific group, a basic knowledge of their heritage and homeland is necessary. In the national language of the Philippines, Tagalog, there is no "F" sound; therefore the spelling of Pilipino and Philipina is used in this paper to represent a more culturally sensitive usage (Stern, Tilden & Maxwell, 1985). Pilipino is used for the male person and general reference to the culture; Philipina is used for the female person. In the case of direct quotations, the original spelling is used.

The Philippines are a chain of over 7000 islands. The islands are bounded by Formosa in the north, Borneo in the south, the Pacific on the east and the China Sea on the west. Many of the islands are uninhabited. Most of the people reside in the coastal plains.

The Pilipinos are descended from many different racial groups. There is evidence of settlement as early as 20,000B.C. The Negritos were probably the first to arrive by crossing land bridges from the Asian mainland. Other inhabitants came from Indonesia, Malaysia, China, Celebes, Borneo, and India. During

the three hundred years of Spanish domination, there was a further blending of racial strains (Aquino, 1981).

The Spanish influence is further reflected in the large number, a majority, of Christians found in the Philippines. The United States added the ideals of public education and democracy. "The Filipinos assimilated nearly all these cultural and political changes without losing their sense of dignity and identity. Attitudes, values, customs, and traditions existing before Magellan were retained and blended with Western concepts" (Aquino, 1981, p. 169). The family remained a primary concern of the culture.

The Family

"The family is one of the most important institutions in the Filipino social structure" (Affonso, 1978, p. 132). Extended families, residing in the same house or nearby, are common. Three generations are often found in the same home. This increases the resources available to each member and also provides a common culture where members interact with each other in reciprocal roles.

"The family is regulated by means of rule of descent, rule of inheritance and rule of residence; as a social unit, it is regulated by customs, traditions, beliefs and laws" (Aquino, 1981, p. 171). Social cohesion is based on reciprocity which is maintained through mutual concern and economic cooperation and mutual love and respect (Aquino, 1981).

When ill, a person relies on his/her family members for support, advice and care taking. During the childbearing year and most of her life, a Pilipina woman seeks council from her mother or mother-in-law. This can be a great problem when the family remains in the Philippines and the woman lives elsewhere. She then relies on her husband and friends.

Social Acceptance

Pilipinos place great importance on the achievement and maintainance of social acceptance in all human interactions through smooth interpersonal relationships and sensitivity to personal affront (Yengoyan & Makil, 1984). It is very desirable to agree with the leader, authority or majority. For example: In a four-bed room, the nurse asks the group if the present time, now, would be a good time for a discussion on infant care. Three women readily agree. The fourth woman soon agrees. After the discussion, the nurse found out that the fourth woman had visitors in the waiting room, but had not wanted to disagree with the group; she went along with the majority.

Harsh, insulting words and bluntness of speech are frowned upon. For example, if a Pilipina client distrusts her care giver, she will seldom say it to his/her face. Instead, she will beat around the bush, use another care giver, or not show up for appointments (DeGarcia, 1979).

The use of yes and no are based on smooth interpersonal relations. In the Pilipino language, the term used for yes and no depends on the status of the person being spoken to; whether

he/she is of lower, equal or higher status. A silent nod avoids giving possible offense. The silent nod is also a defense mechanism use in a belittling situation.

Cultural Beliefs That May Influence Health Care

Pilipinos use both their own healing system and Western medicine (Orque, 1983, p. 159). The Pilipino cultural healing system has integrated many other cultural influences into it. "Unlike Western thinking, the Filipinos view of causality of illness rarely uses the one cause/one effect pattern" (Orque, 1983, p. 160). The causes may be attributed to natural/ physical or supernatural causes. Natural causes include exposure to excess heat/cold, exposure to wind, overeating, overwork, inadequate food or sleep, and unclean environment, overanxiety, excessive drinking, physical abuse of the body, infections and/or accidents (Hart, 1981; Orque, 1983). Supernatural cause include punishment from God, evil spitits, souls of the dead, evil people, and/or witches (Orque, 1983).

When ill, the Pilipino may try home remedies such as special preparatons, teas, massage, as well as sleep and exercise (McKenzie & Chrisman, 1977). If home remedies fail, he/she next consults the indigenous curer or Western physician.

Prevalent Diseases

According to Orque, (1983, p. 172) the following diseases are prevelent in the Pilipino: (1) hyperuricemia; (2) coccidiomycosis; (3) glucose-6-phosphate deficiency (G-6-PD); (4) alpha thalassemia (hemoglobin H disease); (5) cardiovascular-

renal disease; (6) diabetes mellitus; (7) liver cancer; (8) amyotrophic lateral sclerosis (ALS); (9) thyrotoxic periodic paralysis; (10) tuberculosis; and (11) occupational diseases and incapacities.

Pilipina Attitudes Related to Childbearing

Pregnancy

Pregnancy is usually a happy event, especially if it is the first. However, the husband and perhaps the mother are the only people told. Friends and relatives may soon guess, but unless asked, the woman does not volunteer the information. There is also usually no time focused on wishing for special characteristics in the child; even the sex of the child is not important unless the family has an unequal number of boys and girls (Whiting, 1963).

According to Whiting's study (1963, p. 801) Pilipinos believe that the "period of pregnancy is potentially dangerous for the woman-she is 'in death's balance.' The major source of danger is the jealousy of the not-humans. who will cause miscarriage, even death by striking the woman." Special care must be taken to minimize the danger. For example, if a pregnant woman must go out at night, she should avoid it if possible, and she should carry special charms. A pregnant woman must also avoid close contact with death.

The diet of the Pilipina woman during pregnancy is related to ensuring a healthy baby but also to keeping it small in preparation for an easier delivery. Foods to be avoided or

restricted may include: sweet or sour food, hot spicy foods, rice and starches, fatty foods, soda and alcohol (Affonso, 1978). There are also superstitions attached to certain foods, such as: squid which might tangle the baby's cord around the neck; dark foods like prunes might darken the skin; crabs might cause clubbed fingers and toes (Affonso, 1978).

In the Philippines, as previously discussed, the family is very important. Major decisions are made by the eldest male. During childbearing, both the nuclear and extended family "cluster to provide protection, sanction and support to the childbearing couple" (Stern, Tilden & Maxwell, 1985, p. 114).

Screening Needs

Due to the increased prevalence of some health problems in the Pilipino population, pregnancy screening should include: (1) G-6-PD; (2) alpha thalassemia; (3) beta thalassemia; (4) diabetes; (5) tuberculosis; (6) Hepatitis B (Orque, 1983; Boehme, 1985; Stein, Berg, Jones & Detter, 1984).

Labor & Birth

In the Philippines, according to Whiting's study (1963, p. 804), "little fuss is made over delivery; after all, birth is a 'natural thing' and trouble is not usually anticipated." Key people during labor and delivery include: the husband, the woman's mother and mother-in-law, neighboring women, a few relatives and the midwife or physician. The women generally tend to walk around in early labor and then recline on pillows and/or lean against their husbands in later labor. The woman may bear

"the pain stoically or cry out: (Guthrie & Jacobs, 1967, p. 63). In Affonso's study (1978, p. 145), "63% of the women felt that it was not good to make any noise and that it was better to lie there quietly and take it all in." It is important to discuss with the woman any specific practices she feels are important for a safe, satisfying birth.

Postpartum

In the Philippines the postpartum period follows the traditions of most Asian countries, as previously discussed. The period of seclusion usually lasts 7-40 days with a minimum of activity allowed for the woman. These practices follow the beliefs of the Yin/Yang imbalance and the pollution theory (Horn, 1981; Jensen & Bobak, 1985). This is the period of greatest conflict between traditional beliefs and Western medicine.

Newborn

Childrearing is one of the most important functions of the family. Many Pilipina women believe that the primary purpose of marriage is procreation. According to Aquino (1981, p. 173) "children are desired as the natural outcome of the union of husband and wife." Raising children is generally left to chance, common sense, and the influences of customs, traditions, beliefs, myths, legends, folklore, and current practices. However the child is raised, it is done with love, politeness, and respect (Aquino, 1981).

After birth, according to Aquino, (1981, p. 174) "the newborn is physically cuddled, fondled, sung to, talked to and

rocked to sleep." The baby is picked up whenever it cries. The baby is given boiled water while waiting for the mother's milk to flow. Periodically, the baby is put to the breast to stimulate milk production. A combination of breast and bottle feeding is common, especially if the mother works. As soon as the baby is able to sit on his/her mother's lap, he/she joins the family at the table.

Husband's Role

The husband's role in childbearing is primarily one of support. During the antepartum period the husband is expected to be indulgent of the whims and cravings of his wife. He is expected to provide support and reassurances. During the intrapartum period, he is expected to be with his wife, hold her hand, run errands and again, give support and reassurances. During the postpartum period, the husband may assume some of his wife's household tasks (if no other family is available), care for his wife and help care for and play with the infant (Guthrie & Jacobs, 1967; Affonso, 1978).

Korean Culture

Korean Philosophies and Beliefs

Korean Heritage

The Korean peninsula is strategically located in the heart of the Far East. It juts southward from the northeast of Asia. It is bound on the east by the East Sea, on the west by the Yellow Sea, and adjoins Manchuria and the Maritime Province of Soviet Russia on the north. The islands of Japan lie only one hundred

and twenty miles away to the southeast. China lies about twice as far to the west.

As well as being a geographic link between Asia and Japan, during times of peace, Korea has served as a cultural link. For example, Confucianism and Buddhism, along with other aspects of Chinese culture were introduced to Japan through Korea (Choy, 1979).

There has been an intermingling of blood among the Koreans, Chinese, Manchurians and Japanese. This intermingling did not supersede the native race in any appreciable way (Ha, 1968).

Language

One unique characteristic of Korean culture is the language. Despite the fact that for many years the official written language of the Korean government was Chinese, the Koreans never adopted the Chinese language, although they did borrow words from it. There are minor dialect differences in the Korean language, but not large enough to provide a barrier to understanding. Despite the fact that the Korean people were forced to accept foreign domination through the centuries, they managed to maintain their own cultural identity. Over the centuries Koreans developed as a distinctive people, differing from their neighbors. The Koreans became a nation of one language, one culture and one proud past.

Family

The family is the most important social unit in Korea. Family relationships have a powerful influence in Korean society

at home as well as at work. Young people are still taught to show respect for parents and elders. Confucianism still provides influence on the ways of thinking of the average Korean. Children must obey their parents and teachers, wives are at the command of their husbands and at work the hierarchy of juniors to seniors is strictly maintained (, 1986).

Traditionally, the family has had an essential role to play in ancestor worship. Koreans are proud of their well-defined and closely-welded family organization. The family provides a sense of identity, security, affection, support and continuity. In return, it demands loyalty. The vertical relationships present in the family organization have traditionally seemed more important than the lateral one between husband and wife; although this may be changing. There is a desire, even an obligation to continue the family line. This explains the strong desire for male children, although females are said to also be very important.

In many areas of Korea, the family plays a major role in the choice of a spouse. (Pares, 1985).

Social Principles

Deeply important to the people is a sense of propriety. To behave with decorum, to observe etiquette, to show understanding of what is fitting conduct, are signs of good breeding and sensibility. Korean sense of propriety seems to extend even further than their Asian counterparts. It shows itself in the perception that there is a natural order governing human kind,

its society and environment. This is demonstrated in family and social relationships. Marriage is an example. It is more than desirable; it is necessary for the individual in order to preserve loyalty to one's ancestors (Pares, 1985).

Education is also highly desired. College graduates are seen as potential leaders and contributors to national prosperity. By ensuring education, there is assurance of the continuity of principles and values. Most public high schools are not coeducational. Girls go to one school; boys to another. This is also changing; there has been an increase in coeducational schools.

Cultural Beliefs That May Influence Health Care

Korean beliefs about health care are very similar to other Asian beliefs presented previously. There is a blend of Western and Asian practices.

Korean Women's Attitudes Toward Childbearing

Korean practices during the childbearing year are again very similar to other Asian practices. There is, however, a scarcity of literature and research focusing solely on Korean practices. Several articles link all Asian patients together, but diversity does exist between groups. As discussed earlier, each group does have its own unique cultural practices related to antepartal, intrapartal, and postpartal childbirth practices. As Choi (1986, p. 394) states, "currently, nursing literature does not cover Korean practices related to childbearing and childrearing." The literature available, also scarce, is mainly

from anthropology and sociology perspectives and mainly very dated.

Pregnancy

Far back in Korean history, a conception dream that Koreans believed the mother dreamed before conceiving is recorded. This is called Tae Mong. Even today, "many pregnant women still believe in the Tae Mong before conception" (Choi, 1986, p. 394). Koreans still respect this belief and once a mother has a conception dream, she practices the Tao Kyo ritual for pregnancy. Tao Kyo is a set of rules for safe childbirth. It is practiced by Korean women with varying degrees of compliance. It entails in part, reading classical literature, viewing beautiful objects and keeping oneself serene and optimistic (Choi, 1986).

When a Korean woman becomes pregnant, she carefully follows various proscriptions or taboos. The woman avoids approaching unclean things and especially avoids killing any living thing. She avoids stepping over straw rope, stealing, or doing mischievous things. It is believed that breaking taboos will cause a difficult childbirth, or that the infant will contract a disease or be born retarded, or that some misfortune might strike the family. Therefore, to ensure a healthy child and easy childbirth, the woman and her family must observe the taboos.

As childbirth approaches, there are even more taboos. The family cannot repair the fireplace, patch holes in doors or look at a house on fire. The woman cannot eat rabbit, duck, eggs,

pigeon, squid, shark, crab, peaches or any sacrificial food (Choi, 1986). In order to ensure an easier childbirth, for the month preceding the delivery date, the laundry rope is loosened, all doors are kept open, the husband's clothes are used as a quilt and clothes are borrowed from a woman who had an easy childbirth. Traditionally, the pregnant woman may work up until the time of her labor pains begin. If the family can afford the expense, certain medicines believed to improve her strength may be given to her during the last three months (Osgood, 1951).

Screening Needs

Due to the increased prevalence of some health problems in the Korean population, pregnancy screening should include: tuberculosis, and hepatitis (Stein et al, 1984; Boehme, 1985).

Labor & Birth

In the case of a first pregnancy, traditionally, the woman was sent to her father's house. Generally, the mother-in-law took charge and another woman with experience assisted. The husband may or may not have been present (Osgood, 1951). According to Choi (1986), no male is allowed in the birthing room. In addition, childless women are not allowed in the room for fear of bringing some misfortune on the child. This could cause a conflict if the health care provider is childless.

When labor begins, it is not unusual for the woman to crawl around on her knees, groaning. Then when the baby is about to be born, she lies on her back, with legs outstretched. This is confirmed by Choi (1986). The father may come into the room

after the placenta is removed. Other members of the family, except those who are caring for the mother and infant, do not enter the room for at least seven days.

Postpartum

The traditional postpartum begins with seaweed soup, "tangle" and rice. Any other food is thought to be harmful to the mother. No one hammers nails or washes clothes. Any member of the family who has traveled before the birth is not allowed to enter the room for 21 days after the birth (Choi, 1986).

Newborn

The infant will be treated the same whether it is male or female, although the birth of a male is especially pleasing. The real concern, however, is directed toward the mother, for her potential to bear children is proven (Osgood, 1951). The birth of a child is not as significant as the death of an individual. According to Choi (1986, p. 396), an infant at birth is believed to be little more than a biological organism. If the infant dies, it will receive little more deference than an ordinary animal. If the infant lives, its status is recognized only after a long course of learning and ceremonial activities. The family does also not announce that the infant is healthy, beautiful or fat; this might bring bad luck. People who are in mourning are also not allowed in the house; also those who have witnessed a funeral. These taboos are believed to ensure the infant's healthy growth and the mother's speedy recovery (Choi, 1986).

Some Korean women believe in breastfeeding the infant immediately; others wait until three days. Traditionally fathers have had little to do in caring for the new infant. Usually the mother-in-law or other female relatives provide assistance. The mother is usually confined to bed from three to twenty-one days (Choi, 1986).

Implications for Care

Cultural beliefs, values, traditions and practices, exist for a purpose and are not easily changed. It is important to encourage families to share and "express their feelings as to how their unique culture dictates what is to be done or avoided during childbearing" (Affonso, 1978, p. 150).

The goals of health care should be "(1) to allow assessment or discovery of the practices employed by the clients; and (2) to recognize their supportive value and offer positive reinforcement for their use when appropriate" (Affonso, 1978, p. 150).

In caring to Asian clients, Western health care providers need to learn about their client's specific culture as it affects childbearing and also explain to the client the meaning of Western customs which apply.

It is important for the health care provider to utilize an individual cultural assessment tool. Kay, (quoted in Griffith, 1982, p. 192) provides a tool specific to childbearing. (See Appendix).

The following recommendations for care are meant to serve

only as a guideline. The care provider must be careful not to stereotype clients based on their cultural backgrounds.

Recommendations for Care

(1) Language and Communication: A major problem faced by many Asian clients in this country is the language barrier. There are several different Asian languages and each may have many dialects. It is important to identify which one the client uses, if he/she is not speaking English. This avoids miscommunication. An assessment must also be made as to the depth of understanding of English when the client states that he/she speaks English. If the client does not understand he/she may only nod in order to avoid embarrassment.

There are several factors to consider in communication between a care provider and an Asian client. Some of these are: (1) personal space may be quite extended outside close family situations; (2) authority figures may be treated formally; (3) gender and age are usually important considerations and clients older than the provider should not be addressed by their first names; (4) topics such as sex, tuberculosis and socioeconomic background may be too personal and need a very sensitive approach; and (5) clients may be more comfortable with a provider of the same sex (Orque, 1983). An additional difficulty may arise if the provider begins an interview without a "feeling out period." Safe topics include the weather or general health of the family.

Many times, the Asian husband will act as a spokesman for his wife. "Even though he may speak English well, frequently, there is an inability to describe his wife's complaints adequately. When words and phrases are spoken to persons with a different history and a different culture, this difference in context can lead to unintentional inferences being drawn" (Chung, 1977, p. 71).

Additional aids to better communication include: "(1) use of a translator when possible; (2) speaking slowly, using simple medical terms and decreased slang and medical jargon; and (3) one-on-one teaching/interviews related to sensitive topics such as sex and birth control" (Orque, 1983, p. 159).

The translator utilized may be a family member, a friend, another health care provider or an official translator. In any case, the translator needs to be instructed to translate exactly what is said. Translators should not interpret what they think someone means. Tien-Hyatt (1987) states the following case. The case involved a Korean former prostitute who married an American soldier while he was stationed in Korea. When she went to the clinic for care, the staff called in an elderly Korean man to interpret. The interpreter had been considered a leader in his community. He was ashamed because the woman had become a prostitute, married an American and sought help for a mental disorder. The staff later found out that the interpretation had been affected by stigma and infiltrated with condemnation,

thereby reducing the therapeutic benefits of the treatment. This man was interpreting, not translating.

Even if translators are available, the woman may not communicate freely through a male translator and may not allow a male translator in the room during any part of the examination. Historical data may be difficult to obtain. There may have been a lack of formalized medical care in her homeland and the woman may not be familiar with disease names and terminology. This will most likely result in a completely negative personal and family medical history. Past pregnancy losses and length of gestation may not be known. Menstrual history may be vague and the last menstrual period not known. This in itself provides a challenge to the care provider.

(2) Food and Nutrition: Nutritional information given by a Western health care provider may be in direct conflict with the client's cultural practices. This is not known by the provider unless he/she is aware of the dietary practices of the client. Clients may not explain their practices to providers. They may concur with the prescribed diet and go home to follow their traditional diet. It is important for the provider to acknowledge that differences in practices may exist and discuss them with the client and help by suggesting dietary measures that are not in conflict with the client's beliefs.

The health care health care provider needs to be aware of the beliefs in Yin and Yang, as well as dietary prescriptions and

proscriptions (taboos). These beliefs can be incorporated into the plan of care.

(3) Traditional Medicine: The health care provider needs to be aware that clients may be utilizing traditional medical practices. The provider must accept the importance of this system and utilize it to the client's advantage. As long as practices are not detrimental to the client's health, they can be incorporated into the plan of care. If practices are contraindicated, careful explanation of the problem and alternatives need to be discussed with the client. By blending traditional remedies with scientific cures, the provider can bridge the communication gap between the herself/himself, the nurse, client and the family, thereby increasing trust. Once trust has been established, the client and the family are more likely to be open to replacing potentially harmful folk practices with medically approved ones.

(4) Awareness of Philosophical Influences: Many Asian clients have a strong belief in the values set down through Buddhism, Confucianism, Taoism, and Phi. These beliefs have been handed down through centuries and are not easily changed; nor should they be. An understanding of these beliefs can help the provider to better understand why a client acts the way he/she does. The provider may not agree with the beliefs but he/she can accept them as important to the client. For example, many Western care providers cannot understand a woman following her husband's wishes without question. But when it is understood why

the woman follows these wishes, the care provider can accept the client's actions.

(5) Family Involvement: As previously discussed, the family plays a key role in the life of the Asian person and in his/her health care. Family members should be encouraged to participate in health care in ways they feel are appropriate. This may include physical care, bringing traditional foods and emotional support.

(6) Privacy and Modesty: Most Asian women are brought up with strict regard to maintaining modesty. It is important for the provider to respect this value and allow for privacy. Many women, as previously discussed will be more comfortable with a female provider and translator, as well as the support of a husband and/or mother. Whenever possible, these practices should be utilized when caring for the Asian client.

(7) Educational Programs: Educational programs related to pregnancy and childbearing should be offered to Asian women. These programs should be offered in the learner's native language. Visual teaching aids as well as body language can be very effective. These programs can blend traditional beliefs with Western beliefs. The value and importance of both systems should be stressed.

In Western society, especially in the military, where Asian women are marrying American men, it is also important to educate men in the ways of Asian culture. To decrease anxiety, stress and confusion, it is necessary for the husband to understand why

his wife is doing something. Communication about the couple's conflicting beliefs needs to be encouraged.

Due to the scarcity of literature and research on Asian, especially Korean childbearing practices, research would greatly enhance the knowledge available and subsequently the quality of care available to these clients.

SUMMARY

"Practices in childbearing and childrearing differ among the world's cultures, even though most of them are aimed at promoting growth and welfare" (Griffith, 1982, p. 183). These practices are based on superstition, beliefs, values, and traditions. As stated before, they exist for a reason. If the practice is not harmful, and is important to the client, it should be accepted and incorporated into the plan of care.

The preceding presentation was meant to serve as a general guideline to care of the transcultural client with specific emphasis placed on the Mexican-American and Asian women (Pilipina and Korean). It is not the only way. Each client must be assessed individually and their specific beliefs, values and practices noted. Not all clients will have all of the preceding characteristics. But "by understanding the basic philosophical tenets...one is better prepared to understand, it not able to accept, the cultural differences and behavior" (Kubota & Matsuda, 1982, p. 21).

APPENDIX: A CHILDBEARING CULTURAL ASSESSMENT TOOL

(Kay, quoted in Griffith, 1982, p. 182)

ANTEPARTUM

Who may have a child?

At what age?

By whom may one have a child?

How many children can one have?

Can one space pregnancies?

What should be the behavior during pregnancy?

Are there any restrictions on the father?

Are there any restrictions on sexual activity?

Who may see and touch certain body parts?

How is the fetus formed?

What are the beliefs regarding contraception?

INTRAPARTUM

What causes labor?

How does one behave during labor?

How should one respond to pain?

Should one take medication?

Where should labor take place?

POSTPARTUM

What general behavior is expected?

What behavior is expected of the father and others?

Are there any restrictions on food or activity?

CARE OF THE NEWBORN

When is he/she recognized?

What are the rules for his/her care?

Who cares for him/her?

POSTTEST

Choose the most correct answer:

1) Transcultural nursing is:

- A. An evolving body of knowledge and practices regarding health and illness care patterns
- B. A blending of anthropology and nursing
- C. Customs and shared behaviors of certain people
- D. A group's affiliation due to shared linguistic, racial and/or cultural background

1.A,B 2.A,C 3.B,D 4.C,D

2) Denial of the existence of an indigenous/traditional health care system by a Western provider, may result in:

- A. An overdose of medication secondary to concurrent treatments by both systems
- B. An early entry into prenatal care
- C. A refusal by the patient to follow prescribed regimens of care

1.A,B,C 2.A,B 3.B,C 4.A,C

3) The goal of Transcultural Health Care is:

- A. To provide culturally specific care to clients of different cultures
- B. To assimilate the clients of different cultures into the Western health care model.
- C. To identify, test and use Transcultural knowledge and practices.

1.A,B 2.A,C 3.B,C 4.A,B,C

4) The increased focus on Transcultural Health Care has occurred due to:

- A. An increased frequency of world travel
- B. The desire to decrease tensions between countries
- C. Client expectations that health providers will be sensitive to their cultural beliefs and customs

1.A,B 2.A,C 3.B,C 4.A,B,C

5) Ethnocentric tendencies of the care provider may result in:

- A. Client/provider misunderstandings
- B. A client being labelled as noncompliant
- C. The client refusing to return for follow-up care
- D. The use of a culturological assessment tool by the provider

1.A,B,C 2.A,B,D 3.A,C,D 4.B,C,D

6) Why is it important for a health care provider to be aware of Mexican-American beliefs and practices?

- A. A rapidly expanding Mexican-American population
- B. A decreasing fertility rate in the above population
- C. A relatively high perinatal mortality rate in the above population
- D. A higher fertility rate in the above population

1.A,B,C 2.A,B,D 3.A,C,D 4.B,C,D

7) Choose the philosophical attitudes which may cause conflict between the Mexican-American client and the Anglo health care provider.

- A. Religion
- B. Respect for authority figures
- C. Role of women
- D. Traditional folk medicine

1.A,B,C 2.A,B,D 3.A,C,D 4.B,C,D

The following scenario applies to questions 8 through 12.

Rosa Garcia is a 23 year old Mexican-American woman. This is her second pregnancy.

8) When scheduling Mrs. Garcia for her initial prenatal visit, what factors should you consider?

- A. Language barrier
- B. Attitudes towards privacy
- C. Time of day
- D. Family involvement

1.A,B,C 2.A,B,D 3.A,C,D 4.B,C,D

9) Due to the prevalence of certain diseases within the Mexican-American population, which prenatal screening tests should be considered for Mrs. Garcia?

- A. One hour glucose screen
- B. Human Immunovirus (HIV)
- C. Hepatitis B
- D. Serum electrolytes

1.A,B 2.A,C 3.B,C 4.A,D

10) Mrs. Garcia is admitted into labor and delivery in active labor. Current L&D policy allows only two visitors per patient. She would like her husband, mother, two sisters, and mother-in-law to be with her continuously. How should you deal with this situation?

- A. Initiate a change in L&D policy
- B. Allow only her partner and mother to be with her and have all the others go home
- C. Explain to the Garcia family that only two visitors are allowed, but they may alternate as desired.

1.A,B 2.A,C 3.A,D 4.B,C

11) Postpartum or LaDieta is considered the most important time during childbearing for the Mexican-American client. What traditional practices might Mrs. Garcia follow?

- A. Avoid bathing
- B. Use of a faja
- C. Avoid sexual intercourse for the first 40 days
- D. Special precautions to avoid all "cold" foods

1.A,B,C 2.A,B,D 3.B,C,D 4.A,B,C,D

12) Mrs. Garcia comes into clinic for her six weeks postpartum visit. She is uncertain about birth control, but thinks she would like a method. What Mexican-American cultural factors might influence her choice?

- A. Desire to control family size
- B. Attitudes towards modesty
- C. Knowledge of reproduction
- D. Religion

1.A,B,C 2.A,B,D 3.B,C,D 4.A,B,C,D

13) According to the United States Bureau of Census, the term Asian may include people from:

- A. China, Korea, Taiwan
- B. Philippines, India, Vietnam
- C. Japan, Cambodia, Hawaii
- D. Philippines, Japan, Cambodia

1.A,B 2.A,C 3.A,D 4.B,C

14) Common Asian values are:

- A. Male authority and dominance
- B. Saving face
- C. Respect for elders and authority figures
- D. Buddhism

1.A,B,C 2.A,B,D 3.B,C,D 4.A,B,C,D

15) When providing care to the Asian client, factors to consider are:

- A. Respect for authority figures
- B. The client's degree of assimilation into Western culture
- C. Family involvement
- D. Saving face

Questions 16 through 18 apply to the following scenario:

Maria Jones is a 17 year old Gravida 1 Para 0, Pilipina client who recently arrived in the U.S. with her American husband. She is at 16 weeks gestation.

16) What are some cultural barriers you may face in caring for Mrs. Jones?

- A. Language
- B. Food preferences & diet
- C. Compliance with prescribed medications

1.A,B 2.A,C 3.E,C 4.A,B,C

17) At 28 weeks gestation Mrs. Jones' total weight gain for the pregnancy is 7 pounds. She has been counselled on diet and nutrition and agreed to follow the diet plan. In the last week she has gained no weight. What issues may pertain to this problem?

- A. Attempts by Mrs. Jones to please her provider by agreeing with the diet
- B. Availability of familiar foods
- C. Beliefs that not gaining weight will ensure an easy delivery

1.A,B 2.A,C 3.B,C 4.A,B,C

18) During the postpartum period, common practices for Mrs. Jones could be:

- A. Confinement for 7-80 days
- B. Avoidance of water
- C. Eating green vegetables, fruits, and meat
- D. Eating rice, eggs, and chicken soup

1.A,B 2.B,C 3.C,D 4.B,D

19) Due to the prevalence of certain diseases in the Pilipino and Korean populations which lab screening tests may be appropriate for the prenatal client?

- A. HIV
- B. Hepatitis B
- C. Tuberculosis
- D. Electrolytes

1.A,B 2.A,C 3.B,C 4.C,D

20) Health care for clients of other cultures can be improved by:

- A. Use of a translator
- B. Use of pictures & diagrams
- C. Establishing standardized care plans for each culture

1.A,B 2.B,C 3.A,C 4.A,B,C

ANSWERS TO POSTTEST

- 1) 1
- 2) 4
- 3) 2
- 4) 4
- 5) 1
- 6) 3
- 7) 3
- 8) 2
- 9) 1
- 10) 2
- 11) 1
- 12) 4
- 13) 3
- 14) 1
- 15) 4
- 16) 4
- 17) 4
- 18) 4
- 19) 3
- 20) 1

Transcultural Health Care References

- Branch, M. F., & Paxton, P. P. (1976). Providing safe nursing care for ethnic people of color. Norwalk, CT: Appleton-Century Crofts.
- Brink, P., & Saunders, J. (1976). Culture: Theoretical and applied. In P. J. Brink (Ed.), Transcultural Nursing: A Book of Readings (pp. 126-138). Englewood Cliffs, NJ: Prentice-Hall, Inc.
- Brownlee, A. T. (1978). Community, culture, and care: A cross-cultural guide for health workers. St Louis: The C.V. Mosby Co.
- Dawes, T. (1986). Multicultural nursing. International Nursing Review, 33 (5), 148-150.
- Hall, E. T., & Whyte W. F. (1976). Intercultural communication: A guide to men of action. In P. J. Brink (Ed), Transcultural nursing: A book of readings (pp. 44-62). Englewood Cliffs, NJ: Prentice-Hall, Inc.
- Jensen, M. D., & Bobak, I. M. (1985). Maternity and gynecological care: The nurse and the family (pp.65-77). St. Louis: C.V. Mosby Co.
- Kluckhohn, F. R. (1976). Dominant and variant value orientations. In P. J. Brink (Ed), Transcultural nursing: A book of readings (pp. 63-81). Englewood-Cliffs, NJ: Prentice-Hall, Inc.
- Leininger, M. (1970). Nursing and anthropology: Two worlds to blend. New York: John Wiley and Sons.

- Leininger, M. (1978). Transcultural nursing: concepts, theories, and practices. New York: John Wiley and Sons.
- MacGregor, F. C. (1976). Uncooperative patients: Some cultural interpretations. In P. J. Brink (Ed), Transcultural nursing: A book of readings. Englewood-Cliffs, NJ: Prentice-Hall, Inc.
- O'Brien, E. (1982). Pragmatic survivalism: Behavior patterns affecting low-level wellness among minority group members. Advances in Nursing Science, 4, 13-26.
- Osborne, O. (1976). Anthropology and Nursing: Some common traditions and interests. In P.J. Brink, (Ed), Transcultural nursing: A book of readings. (pp. 18-26). Englewood Cliffs, NJ: Prentice-Hall, Inc.
- Orque, M. S., Bloch B., & Monrroy, L. S. A. (1983). Ethnic nursing care: A multicultural approach. St Louis: The C.V. Mosby, Co.
- Rothenburger, R. L. (1987). Understanding cultural differences is the key to transcultural nursing. Association of Operating Room Nurses, 45 (5), 1204-8.
- Spector, R. E. (1985). Cultural diversity in health and illness (2nd Ed). Norwalk, CT: Appleton-Century Crofts.
- Thornton-Williams, S. (1987). Cultural considerations for childbirth education: Outreach efforts for ethnic Chinese and Mien refugees from southeast Asia. NAACOG Update Series, 5, 2-8.

Tripp-Reimer, T., Brink, P., & Saunders, J. (1984). Cultural assessment: Content and process. Nursing Outlook, 32 (2), 78-82.

Werner, E.E. (1979). Cross-cultural child development: A view from the planet earth. In M. S. Orque, B. Bloch, & L. S. A. Monrroy (1983), Ethnic nursing care: A multicultural Approach, St. Louis: The C.V. Mosby Co.

Mexican-American References

- Alvirez, D., Bean, F., & Williams, D. (1981). The Mexican-American family. In R. Habenstein & C. Mindel (Eds.), Ethnic families in America: Patterns and variations (Chap 12). New York: Elsevier.
- Bullough, B., & Bullough, V. L. (1982). Health care for other Americans. New York: Appleton-Century-Crofts.
- Clark, M. (1959). Health in the Mexican-American culture. Berkley: University of California Press.
- Danneskiold, C. L. (1980). Nutrition in pregnancy: A community study, Unpublished thesis, University of Utah, College of Nursing, Salt Lake City.
- Ehling, M. B. (1981). The Mexican-American (El Chicano). In A. L. Clark (Ed.), Culture and childrearing (pp. 192-209). Philadelphia: F.A. Davis Co.
- Gonzalez-Swofford, M. J. (1983). Ethno-medical beliefs and practices of Mexican-Americans. Nurse Practitioner, 8 (10), 29-34.
- Hispanics rise. (1987, November). Parade Magazine, p.13
- Holland, W. R. (1978). Mexican-American medical beliefs: Science or magic? In R. Martinez (Ed.), Hispanic culture and health care (fact, fiction, folklore) (Chap 8). St. Louis: The C. V. Mosby Co.
- Jensen, M. D. & Bobak, I. M. (1985). Maternity and gynecologic care: The nurse and the family. St. Louis: The C. V. Mosby Co.

- Johnson, C. A. (1978). Nursing and Mexican-American folk medicine. In R. Martinez (Ed.), Hispanic culture and health care (fact, fiction, folklore) (Chap 9). St. Louis: The C. V. Mosby Co.
- Kay, M. (1978). Mexican American. In A. L. Clark (Ed.), Cultural, childbearing and health professionals (Chap 6). Philadelphia: F. A. Davis Co.
- Koster, V. A. (1986). Abuelas: Traditional and transitional involvement in childbirth, Unpublished thesis, University of Utah, College of Nursing, Salt Lake City.
- Lasater, T. T. & Montalvo, F. F. (1982). Understanding Mexican-American culture: A training report. Children Today, 11 (3), 23-25.
- Mardiros, M. (1984). A view toward hospitalizations: The Mexican-American experience. Journal of Advanced Nursing, 9, 469-78.
- Martinez, A. (1983). Prenatal care: Attitudes and trends of usage among Mexican-American women, Unpublished thesis, University of Utah, College of Nursing, Salt Lake City.
- Martinez, R. (1978). Cultural considerations: Introduction to the Hispanic life styles. In R. Martinez (Ed.), Hispanic culture and health care (fact, fiction, folklore) (pp.1-2). St. Louis: The C. V. Mosby Co.
- Murillo, N. (1978). The Mexican-American family. In R. Martinez (Ed.), Hispanic culture and health care (fact, fiction, folklore) (Chap 1). St. Louis: The C. V. Mosby Co.

- Murillo-Rohde, I. (1981). Hispanic American patient care. In G. Henderson & M. Primeaux (Eds.), Transcultural health care (Chap 15). Menlo Park, CA: Addison-Wesley Publishing Co.
- Samora, J. (1978). Conceptions of health and disease among Spanish-Americans. In R. Martinez (Ed.), Hispanic culture and health care (fact, fiction, folklore) (Chap 5). St. Louis: The C. V. Mosby Co.
- Star, W. L., Shannon, M. T., Sammons, L. N., Neeson, J. D., & Gutierrez, Y. (1987). Ambulatory obstetrics: Protocols for nurse practitioners and nurse-midwives. San Francisco: University of California.
- Stenger-Castro, E. (1978). The Mexican-American: How his culture affects his mental health. In R. Martinez (Ed.), Hispanic culture and health care (fact, fiction, folklore) (Chap 2). St. Louis: The C. V. Mosby Co.
- Tamez, E. (1985). Familism, machismo and childbearing among Mexican-Americans. Journal of Psychosocial Nursing, 19 (9), 21-25.
- Wang, R. (1976). Health care needs of the Mexican-American. Ethnicity and health care. New York: National League for Nursing.
- White, V. K. (1985). The experience of pregnancy among Hispanic women, Unpublished thesis, University of Utah, College of Nursing, Salt Lake City.

Zepeda, M. (1982). Selected maternal-infant care practices of Spanish-speaking women. Journal of Obstetrical and Gynecological Nursing, 11 (6), 371-374.

Asian References

- Affonso, D. D. (1978). The Filipino-American. In A. L. Clark (Ed.), Culture, childbearing, health professionals (pp. 129-153). Philadelphia: F. A. Davis, Co.
- Aquino, C. J. (1981). The Filipino in America. In A. L. Clark (Ed.), Culture and childrearing (pp. 166-190). Philadelphia: F. A. Davis, Co.
- Bates, B. & Turner, A. N. (1985). Imagery and symbolism in birth practices of traditional cultures. Birth, 12, 29-35.
- Boehme, T. L. (1985). Hepatitis B: The nurse-midwife's role in management and prevention. Journal of Nurse-Midwifery, 30, 79-87.
- Campbell, T. & Chang, B. (1973). Health care of the Chinese in America. Nursing Outlook, 21, 245-249.
- Choi, E. C. (1986). Unique aspects of Korean-American mothers. Journal of Obstetrical, Gynecological and Neonatal Nursing, 15, 394-400.
- Choy, B. Y. (1979). Koreans in America. Chicago: Nelson-Hall.
- Chung, H. J. (1977). Understanding the Oriental maternity patient. Nursing Clinics of North America, 12, 67-75.
- DeGarcia, R. T. (1979). Cultural influence on Filipino patients. American Journal of Nursing, 79, 1412-1414.
- Griffith, S. (1982). Childbearing and the concept of culture. Journal of Obstetrical and Gynecological Nursing, 11, 181-184.

- Guthrie, G. M. & Jacobs, P. J. (1967). A child's birth into a family. In G. M. Guthrie & P. J. Jacobs (Eds.), Childrearing in the Philippines (pp. 57-83). Manila: Pennsylvania University Press.
- Ha, T. H. (1968). Guide to Korean culture. Seoul: Yonsei University Press.
- Hart, D. D. (1981). Bisayan Filipino and Maylayan folk medicine. In G. Henderson & M. Primeaus (Eds.), Transcultural health care (pp. 148-161). Menlo Park, CA: Addison-Wesley Publishing Co.
- Hollinsworth, A. O., Brown, L. P. & Brooten, D. A. (1980). The refugee and childbearing: What to expect, RN, 43, 45-48.
- Horn, B. M. (1981). Cultural concepts and postpartal care. Nursing & Health Care, 2, 516-517, 526-527.
- Jensen, M. D. & Bobak, I. M. (1985). Maternity and gynecological care: The nurse and the family (pp. 65-77). St. Louis: The C. V. Mosby Co.
- Kendall, L. & Dix, G. (Eds.). (1987). Religion and ritual in Korean society. Berkeley, CA: Institute of East Asian Studies.
- Kubota, J. & Matsuda, J. K. (1982). Family planning services for Southeast Asian refugees. Family and Community Health, 5, 19-28.
- McKenzie, J. L. & Chrisman, N. J. (1977). Healing herbs, gods, and magic: Folk health beliefs among Filipino-Americans. Nursing Outlook, 25, 326-329.

- Muecke, M. A. (1983). Caring for Southeast Asian refugee patients in the United States. American Journal of Public Health, 73, 431-439.
- Nelson, C. C., Hewitt, M. A. (1983). An Indochinese refugee population in a nurse-midwifery service. Journal of Nurse-Midwifery, 28, 9-14.
- Orque, M. S. (1983). Nursing care of Filipino-American patients. In M. S. Orque, B. Block, & L. S. Monrroy (Eds.), Ethnic nursing care (pp. 149-181). St. Louis: C. V. Mosby Co.
- Osgood, C. (1951). The Koreans and their culture. Tokyo: Charles E. Tuttle Co.
- Pares, S. (1985). Crosscurrents. Seoul: International Publishing House.
- Stein, J., Berg, C., Jones, J. A., & Detter, J. C. (1984). A screening protocol for a prenatal population at risk for inherited hemoglobin disorders: Results of its application to a group of Southeast Asians and blacks. American Journal of Obstetrics and Gynecology, 1501, 333-339.
- Stern, P. N., Tilden, V. P. & Maxwell, E. K. (1985). Culturally induced stress during childbearing: The Philipino-American experience. Health Care of Women International, 6, 105-121.
- Thornton-Williams, S. (1987). Cultural considerations for childbirth education: Outreach efforts for ethnic Chinese and Mien refugees from Southeast Asia. NAACOG Update Series, 5, 2-8.

- Tien-Hyatt, J. I. (1987). Keying in on unique care needs of Asian clients. Nursing and Health Care, 8, 269-271.
- Wang, R. M. (1976). Chinese Americans and health care. In Ethnicity and health care (pp. 9-19). New York: National League for Nursing.
- Whiting, B. B. (1963). Tarong: An Ilococ barrio in the Philippines. In B. B. Whiting (Ed.), Six cultures: Studies in childrearing (pp. 777-867). New York: John Wiley & Sons, Inc.
- Yengoyan, A. A. & Makil, P. Q. (1984) Philippine society and the individual (pp. 29-81). Ann Arbor, MI: Michigan Papers on South and Southeast Asian Center for South and Southeast Asian Studies.
- (). (1986). Focus on Korea: This is Korea. Seoul: International Publishing House: Korean Overseas Information Service.